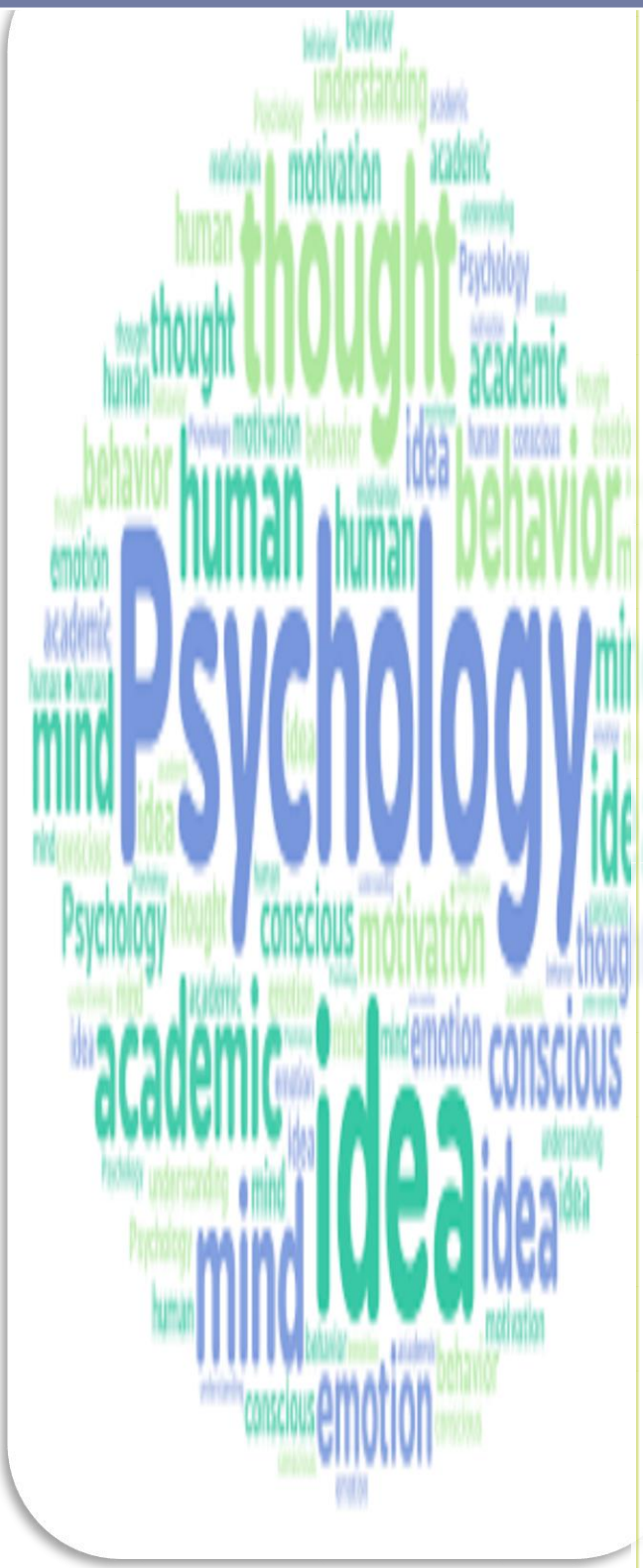
# UNIT-9 Human Development and Interventions

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What is Developmental processes: Nature, Principles, Factors in development, Stages of Development. Successful aging. Theories of development: Psychoanalytical, Behavioristic, and Cognitive Various aspects of development: Sensory-motor, cognitive, language, emotional, social and moral?

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## Developmental processes: Nature, Principles, Factors in development, Stages of Development

an**Developmental Psychology**

Developmental psychology is the scientific study of changes that occur in human beings over the course of their lives. This field examines change and development across a broad range of topics, such as motor skills and other psycho-physiological processes; cognitive development involving areas like problem solving, moral and conceptual understanding; language acquisition; social, personality, and emotional development; and self- concept and identity formation. Developmental psychology explores the extent to

which development is a result of gradual accumulation of knowledge or stage-like development, as well as the extent to which children are born with innate mental structures as opposed to learning through experience.

**Nature Versus Nurture**

A significant issue in developmental psychology is the relationship between the innateness of an attribute (whether it is part of our nature) and the environmental effects on that attribute (whether it is influenced by our environment, or nurture). This is often referred to as the nature vs. nurture debate, or nativism vs. empiricism.

- A nativist (“nature”) account of development would argue that the processes in question are innate and influenced by an organism’s genes. Natural human behavior is seen as the result of already-present biological factors, such as genetic code.
- An empiricist (“nurture”) perspective would argue that these processes are acquired through interaction with the environment. Nurtured human behavior is seen as the result of environmental interaction, which can provoke changes in brain structure and chemistry. For example, situations of extreme stress can cause problems like depression.

The nature vs. nurture debate seeks to understand how our personalities and traits are produced by our genetic makeup and biological factors, and how they are shaped by our environment, including our parents, peers, and culture. For instance, why do biological children sometimes act like their parents? Is it because of genetic similarity, or the result of the early childhood environment and what children learn from their parents?

## Interaction of Genes and the Environment

Today, developmental psychologists rarely take such polarized positions (either/or) with regard to most aspects of development; instead, they investigate the relationship between innate and environmental influences (both/and). Developmental psychologists will often use the biopsychosocial model to frame their research: this model states that biological, psychological, and social (socio-economical, socio-environmental, and cultural) factors all play a significant role in human development.

We are all born with specific genetic traits inherited from our parents, such as eye color, height, and certain personality traits. Beyond our basic genotype, however, there is a deep interaction between our genes and our environment: our unique experiences in our environment influence whether and how particular traits are expressed, and at the same time, our genes influence how we interact with our environment (Diamond, 2009; Lobo, 2008). There is a reciprocal interaction between nature and nurture as they both shape who we become, but the debate continues as to the relative contributions of each.

Heritability refers to the origin of differences among people; it is a concept in biology that describes how much of the variation of a trait in a population is due to genetic differences in that population. Individual development, even of highly heritable traits such as eye color, depends not only on heritability but on a range of environmental factors, such as the other genes present in the organism and the temperature and oxygen levels during development. Environmental inputs can affect the expression of genes, a relationship called gene-environment interaction. Genes and the environment work together, communicating back and forth to create traits.

## Research Methods

Developmental psychology employs many of the research methods used in other areas of psychology; however, infants and children cannot be tested in the same ways as adults. To study changes in individuals over time, developmental psychologists use systematic observation, including naturalistic or structured observation; self-reports, which could be clinical interviews or structured observation; clinical or case study methods; and ethnography or participant observation. Three research methods used include the *experimental, correlational,* and *case study approach.*

## Experimental Research

The experimental method involves actual manipulation of treatments, circumstances, or events to which the participant or subject is exposed. This design points to cause-and-effect relationships and thus allows for strong inferences to be made about causal relationships between the manipulation of one or more independent variables and subsequent subject behavior. A limit to this method is that the artificial environment in which the experiment is conducted may not be applicable to the general population.

## Correlational Research

The correlational method explores the relationship between two or more events by gathering information about these variables *without* researcher intervention. The advantage of using a correlational design is that it estimates the strength of a relationship among variables in the natural environment. However, the limitation is that it can only indicate that a relationship exists between the variables; it cannot determine which one *caused* the other.

## Case Study

In a case study, developmental psychologists collect a great deal of information from one individual in order to better understand physical and psychological changes over his or her lifespan. Data can be collected through the use of interviews, structured questionnaires, observation, and test scores. This particular approach is an excellent way to better understand individuals who are exceptional in some way, but it is especially prone to researcher bias in interpretation, and it is difficult to generalize conclusions to the larger population.

## Research Designs

Regardless of whether studies employ the experimental, correlational, or case study methodology, they can use research designs or logical frameworks to make key comparisons within research studies. These include *longitudinal, cross-sectional, sequential,* and *microgenetic designs*.

## Longitudinal Design

In a longitudinal study, a researcher observes many individuals born at or around the same time (a cohort ) and carries out new observations as members of the cohort age. This method can be used to draw conclusions about which types of development are universal (or normative ) and occur in most members of a cohort. Researchers may also observe ways that development varies between individuals and hypothesize the causes of such variation. Longitudinal studies often require large amounts of time and funding, making them unfeasible in some situations. Also, because members of a cohort all experience historical events unique to their generation, apparently normative developmental trends may only be universal to the cohort itself.

## The Principles of Developmental Psychology

Life-span developmental psychology is the ®eld of psychology which involves the examination of both constancy and change in human behaviour across the entire life span, that is, from conception to death (Baltes, 1987). Developmental psychologists are concerned with diverse issues ranging from the growth of motor skills in the infant, to the gains and losses observed in the intellectual functioning of the elderly.

The goal of study in developmental psychology is to further our knowledge about how development evolves over the entire life span, developing a knowledge of the general principles of development and the differences and similarities in development across individuals. The range of topics comprising the study of modern psychology is vast, and encompasses sub-areas as diverse as social psychology, comparative psychology, the study of learning, neuropsychology, abnormal psychology, and cognitive psychology.

However, the study of development is possible within each of these areas. Thus, in one sense, developmental psychology can be thought of as an approach that one takes to the broader study of psychology (Buss, 1995). This text focuses on a narrower portion of the life span, speci®cally, on the time development between conception and adolescence.

important in its own right but it also has the potential to signi®cantly inform us about the nature of human development. By studying the earlier forms of a behaviour and the changes which behaviour undergoes, we can gain a better understanding of the `end product', that is, adult behaviour. While this text does focus speci®cally on children's development, the wider principles of lifespan

developmental psychology (which we discuss shortly) apply equally to this area as they do to the study of development across the life span.

When we speak of development, to what, in fact are we referring? One frequently used de®nition refers to development as patterns of change over time which begin at conception and continue throughout the life span. Development occurs in different domains, such as the biological (changes in our physical being), social (changes in our social relationships), emotional (changes in our emotional understanding and experiences), and cognitive (changes in our thought processes). Some developmental psychologists prefer to restrict the notion of development only to changes which lead to qualitative reorganizations in the structure of a behaviour, skill or ability (Crain, 2000).

For example, Heinz Werner (1957) argued that development refers only to changes which increase the organization of functioning within a domain. Werner believed that development consisted of two processes: integration and differentiation. Integration refers to the idea that development consists of the integration of more basic, previously acquired behaviours into new, higher level structures. For example, according to Piaget (1952), the baby

who learns to successfully reach for objects has learned to coordinate a variety of skills such as maintaining an upright posture, moving the arm, visually coordinating the position of the hand and the object, and grasping the object under an integrated structure called a scheme. New developments build on and incorporate what has come before. Differentiation refers to the idea that development also involves the progressive ability to make more distinctions among things, for example, learning to adjust one's grasp to pick up small objects (which requires the use of the ®ngers and ®ne motor

control) versus larger objects (which only require closing the hand around the object and less ®ne motor control).

Werner de®ned development as a combination of these two processes of integration and differentiation; he saw development as a process of increasing hierarchical integration and increasing differentiation. Of course, Werner's view of development is by no means universally accepted within developmental psychology. Many developmentalists argue that anything which evidences change over time is relevant to the study of development (Crain, 2000). Thus, this debate remains a tension within the study of human development.

## Principles of life-span development

Paul Baltes (1987) has articulated a set of principles which guide the study of human development within a life-span framework. Baltes argues that these principles form a family of beliefs which specify a coherent view of the nature of development. It is the application of these beliefs as a coordinated whole which characterizes the life-span approach. In this book, although we focus on development in children, we will take a life-span approach to the study of development.

The ®rst of the principles which Baltes (1987) discussed is the belief that development is lifelong. This belief has two separate aspects. First, the potential for development extends across the entire life span: there is no assumption that the life course must reach a plateau or decline during adulthood and old age. Second, development may involve processes which are not present at birth but emerge throughout the life span. Development is also multidimensional and multidirectional. Multidimensionality refers to the fact that development cannot be described by a single criterion

such as increases or decreases in a behaviour. The principle of multidirectionality maintains that there is no single, normal path that development must or should take. In other words, healthy developmental outcomes are achieved in a wide variety of ways.

Development is often comprised of multiple abilities which take different directions, showing different types of change or constancy. Another principle of development is the belief that development involves both gains and losses.

According to Baltes, any developmental process involves aspects of growth and decline. For example, formal schooling increases a child's knowledge base and develops their cognitive abilities but also restricts their creativity as they learn to follow rules de®ned by others. These two aspects of growth and decline need not occur in equal strength, and, moreover, the balance between gains and losses can change with time.

Contextualism in developmental psychology As we have seen, Baltes (1987) stressed the importance of contextualism to the study of life-span development. In order to create a coherent framework for understanding contextual in¯uences, Baltes proposed a three-factor model of contextual in¯uences on development (Baltes, Reese, & Lipsitt, 1980).

The ®rst factor is normative age-graded in¯uences. These are the biological and environmental in¯uences that are similar for individuals in a particular age group. Examples of normative age-graded in¯uences are events such as puberty or the entry into formal schooling.

A second type of in¯uences is what Baltes referred to as normative history-graded in¯uences. These are biological and environmental in¯uences associated with historical periods in time which in¯uence

people of a particular generation. For example, the effects of World War II on much of the world's population or the changes in the structure of government experienced by the people of the Soviet Union during the 1980s would constitute examples of normative history-graded in¯uences.

Nonnormative life events are unusual occurrences that have a major impact on a individual's life. The occurrence of these events is relatively unique to an individual and is not tied to a historical time period. Moreover, the in¯uence of these events often does not follow a typical developmental course.

Being struck with a major illness or losing a parent in childhood are examples of this kind of contextual in¯uence. It is important for developmentalists to recognize that explanations of behavioural development are likely to be complex and require consideration of the wide variety of possible in¯uences on a given individual's development.

## Themes and issues in developmental psychology

A number of major themes have emerged in the study of child development, themes which are recurrent across the various domains of study. For example, the debate over whether development is best characterized as driven by biological or environmental factors has guided study within areas as diverse as emotional, social and cognitive development.

The same is true for each of the other major themes which we will examine. After you become familiar with each of the issues described here, you should think about these themes as you read Chapters 4 through 10. You should be able to identify where these themes occur when studying the areas of development discussed in the last seven chapters.

## Continuity and discontinuity

An important question which continually confronts the researcher in the study of child development is how to best characterize the nature of developmental change. There are two contrasting positions on developmental change. According to those who hold to the ®rst position, development is best viewed as a continuous process.

That is, development is conceived of as a process of the gradual accumulation of a behaviour, skill, or knowledge. On this model, development proceeds in a smooth and orderly fashion, with each change building on previous abilities. In contrast, those who hold to the second view would suggest that developmental change is best characterized asdiscontinuous in nature. These theorists suggest that behaviours or skills often change qualitatively across time, and that new organizations of behaviours, skills, or knowledge emerge in a rather abrupt or discrete fashion.

The notion of a stage of development is central to discontinuous views of development. A stage of development can be thought of as a particular organization of the child's knowledge and behaviour that characterizes their development at a particular point in time.

The movement to a new stage of development means that a qualitative reorganization of previous knowledge or behaviour has taken place. For example, Piaget (1952) believed that between 7 to 11 years of age, children's thinking could be described as concrete, in that it is closely tied to the nature of the objects with which they interact. In contrast, during adolescence, thinking becomes more abstract; it is less bound to particular objects and takes into account the possible or hypothetical. It should be clear that these two positions ± development viewed as a continuous process or as a

discontinuous process ± describe development in quite different ways; ways that on the surface are seemingly dif®cult to reconcile with one another.

Siegler (1998) has argued that whether a particular aspect of development appears to be continuous or discontinuous in nature depends largely on how we choose to examine development. When we examine the change in a given behaviour at large intervals (e.g., yearly) or in different age groups such as 4- year-olds and 8-year-olds, development will tend to look very discontinuous or stage-like. If we plotted the level of development of some skill over time,

the developmental function might look like a staircase, with periods of little change followed by abrupt shifts in the level of performance. In contrast, if we were to examine the behaviour more closely, at smaller intervals, we might ®nd that development took on a much more continuous character.

That is, increases in the level of performance would be seen to occur gradually, with no abrupt shifts. We would also ®nd that there is great variability in the methods or strategies that children use to solve problems. Siegler's (1998) own work on children's learning in the domain of mathematics shows that children often use a variety of strategies in their attempts to learn how to add together

two numbers. Because learning to decide which strategies work best takes some time, the shifts between the use of different strategies is a gradual process. If we plotted the development of strategy use for addition problems, Siegler claims we would obtain a picture quite different from the staircase model just described. Instead, we would see what he calls `overlapping waves' of development.

## Factors in development

Growth and Development Defined?

Although the terms growth and development are used synonymously, they have different meanings biologically. Growth refers to the incremental changes in physical characteristics such as height, weight, size, etc., while development refers to qualitative changes to growth in an orderly and meaningful fashion which results in maturity. Growth and development contribute to each other, are inseparable, and occur simultaneously. For example, most babies, by the time they grow up to be 8 months old, can weigh around 8 to 10 kilograms and can sit up.

10 Factors That Influence the Growth and Development of a Child

Nature and nurture both contribute to the growth and development of children. Although what's endowed by nature is constant, nurture tends to make a big difference too. Here are a few factors affecting children's growth and development.

### 1. Heredity

Heredity is the transmission of physical characteristics from parents to children through their genes. It influences all aspects of physical appearance such as height, weight, body structure, the colour of the eye, the texture of the hair, and even intelligence and aptitudes. Diseases and conditions such as heart disease, diabetes, obesity, etc., can also be passed through genes, thereby affecting the growth and development of the child adversely. However, environmental factors and nurturing can bring the best out of the already present qualities in the genes.

2. Environment

The environment plays a critical role in the development of children and it represents the sum total of physical and psychological stimulation the child receives. Some of the environmental factors influencing early childhood development involve the physical surroundings and geographical conditions of the place the child lives in, as well his social environment and relationships with family and peers. It is easy to understand that a well-nurtured child does better than a deprived one; the environment children are constantly immersed in contributes to this. A good school and a loving family builds in children strong social and interpersonal skills, which will enable them to excel in other areas such as academics and extracurricular activities. This will, of course, be different for children who are raised in stressful environments.

**3. Sex**

The sex of the child is another major factor affecting the physical growth and development of a child. Boys and girls grow in different ways, especially nearing puberty. Boys tend to be taller and physically stronger than girls. However, girls tend to mature faster during adolescence, while boys mature over a longer period of time. The physical structure of their bodies also has differences which make boys more athletic and suited for activities that require physical rigour. Their temperaments also vary, making them show interest in different things.

4. **Exercise and Health**

The word exercise here does not mean physical exercise as a discipline or children deliberately engaging in physical activities knowing it would help them grow. Exercise here refers to the normal playtime and sports activities which help the body gain an increase in muscular strength and put on bone mass.

Proper exercise helps children grow well and reach milestones on time or sooner. Exercise also keeps them healthy and fights off diseases by strengthening the immune system, especially if they play outside. This is because outdoor play exposes them to microbes that help them build resistance and prevent allergies.

5. **Hormones**

Hormones belong to the endocrine system and influence the various functions of our bodies. They are produced by different glands that are situated in specific parts of the body to secrete hormones that control body functions. Their timely functioning is critical for normal physical growth and development in children. Imbalances in the functioning of hormone-secreting glands can result in growth defects, obesity, behavioural problems and other diseases. During puberty, the gonads produce sex hormones which control the development of the sex organs and the appearance of secondary sexual characteristics in boys and girls.

6. **Nutrition**

Nutrition is a critical factor in growth as everything the body needs to build and repair itself comes from the food we eat. Malnutrition can cause deficiency diseases that adversely affect the growth and development of children. On the other hand, overeating can lead to obesity and health problems in the long run, such as diabetes and heart disease. A balanced diet that is rich in vitamins, minerals, proteins, carbohydrates and fats is essential for the development of the brain and body.

**7. Familial Influence**

Families have the most profound impact in nurturing a child and determining the ways in which they develop psychologically and

socially. Whether they are raised by their parents, grandparents or foster care, they need basic love, care and courtesy to develop as healthy functional individuals. The most positive growth is seen when families invest time, energy and love in the development of the child through activities, such as reading to them, playing with them and having deep meaningful conversations. Families that abuse or neglect children would affect their positive development. These children may end up as individuals who have poor social skills and difficulty bonding with other people as adults. Helicopter parenting also has negative effects as they render children dependent on the parents even as young adults and unable to deal with difficulties in life on their own.

## 8. Geographical Influences

Where you live also has a great influence on how your children turn out to be. The schools they attend, the neighbourhood they live in, the opportunities offered by the community and their peer circles are some of the social factors affecting a child's development. Living in an enriching community that has parks, libraries and community centres for group activities and sports all play a role in developing the child's skills, talents, and behaviour. Uninteresting communities can push some children to not go outside often but play video games at home instead. Even the weather of a place influences children in the form of bodily rhythms, allergies and other health conditions.

## 9. Socio-Economic Status

The socio-economic status of a family determines the quality of the opportunity a child gets. Studying in better schools that are more expensive definitely has benefits in the long run. Well-off families can also offer better learning resources for their children and they

afford special aid if the kids need it. Children from poorer families may not have access to educational resources and good nutrition to reach their full potential. They may also have working parents who work too many hours and cannot invest enough quality time in their development.

### 10. Learning and Reinforcement

Learning involves much more than schooling. It is also concerned with building the child up mentally, intellectually, emotionally, and socially so they operate as healthy functional individuals in the society. This is where the development of the mind takes place and the child can gain some maturity. Reinforcement is a component of learning where an activity or exercise is repeated and refined to solidify the lessons learned. An example is playing a musical instrument; they get better at playing it as they practice playing the instrument. Therefore, any lesson that is taught has to be repeated until the right results are obtained.

## Stages of Development

What aspects of ourselves change and develop as we journey through life? We move through significant physical, cognitive, and psychosocial changes throughout our lives—do these changes happen in a systematic way, and to everyone? How much is due to genetics and how much is due to environmental influences and experiences (both within our personal control and beyond)? Is there just one course of development or are there many different courses of development? In this module, we'll examine these questions and learn about the major stages of development and what kind of developmental tasks and transitions we might expect along the way.

## Defining Human Development in Stages

Human development refers to the physical, cognitive, and psychosocial development of humans throughout the lifespan. What types of development are involved in each of these three domains, or areas, of life? Physical development involves growth and changes in the body and brain, the senses, motor skills, and health and wellness. Cognitive development involves learning, attention, memory, language, thinking, reasoning, and creativity. Psychosocial development involves emotions, personality, and social relationships.

### Physical Domain

Many of us are familiar with the height and weight charts that pediatricians consult to estimate if babies, children, and teens are growing within normative ranges of physical development. We may also be aware of changes in children's fine and gross motor skills, as well as their increasing coordination, particularly in terms of playing sports. But we may not realize that physical development also involves brain development, which not only enables childhood motor coordination but also greater coordination between emotions and planning in adulthood, as our brains are not done developing in infancy or childhood. Physical development also includes puberty, sexual health, fertility, menopause, changes in our senses, and primary versus secondary aging. Healthy habits with nutrition and exercise are also important at every age and stage across the lifespan.

### Cognitive Domain

If we watch and listen to infants and toddlers, we can't help but wonder how they learn so much so fast, particularly when it comes to language development. Then as we compare young children to

those in middle childhood, there appear to be huge differences in their ability to think logically about the concrete world around them. Cognitive development includes mental processes, thinking, learning, and understanding, and it doesn't stop in childhood. Adolescents develop the ability to think logically about the abstract world (and may like to debate matters with adults as they exercise their new cognitive skills!). Moral reasoning develops further, as does practical intelligence—wisdom may develop with experience over time. Memory abilities and different forms of intelligence tend to change with age. Brain development and the brain's ability to change and compensate for losses is significant to cognitive functions across the lifespan, too.

## Psychosocial Domain

Development in this domain involves what's going on both psychologically and socially. Early on, the focus is on infants and caregivers, as temperament and attachment are significant. As the social world expands and the child grows psychologically, different types of play and interactions with other children and teachers become important. Psychosocial development involves emotions, personality, self-esteem, and relationships. Peers become more important for adolescents, who are exploring new roles and forming their own identities. Dating, romance, cohabitation, marriage, having children, and finding work or a career are all parts of the transition into adulthood. Psychosocial development continues across adulthood with similar (and some different) developmental issues of family, friends, parenting, romance, divorce, remarriage, blended families, caregiving for elders, becoming grandparents and great grandparents, retirement, new careers, coping with losses, and death and dying.

As you may have already noticed, physical, cognitive, and psychosocial development are often interrelated, as with the example of brain development. We will be examining human development in these three domains in detail throughout the modules in this course, as we learn about infancy/toddlerhood, early childhood, middle childhood, adolescence, young adulthood, middle adulthood, and late adulthood development, as well as death and dying.

## Key Issues in Human Development

There are many different theoretical approaches regarding human development. As we evaluate them in this course, recall that human development focuses on how people change, and the approaches address the nature of change in different ways:

- Is the change smooth or uneven (continuous versus discontinuous)?
- Is this pattern of change the same for everyone, or are there different patterns of change (one course of development versus many courses)?
- How do genetics and environment interact to influence development (nature versus nurture)?

## Is Development Continuous or Discontinuous?

**Continuous development** views development as a cumulative process, gradually improving on existing skills (Figure 2). With this type of development, there is a gradual change. Consider, for example, a child's physical growth: adding inches to their height year by year. In contrast, theorists who view development as **discontinuous** believe that development takes place in unique stages and that it occurs at specific times or ages. With this type of

development, the change is more sudden, such as an infant's ability to demonstrate awareness of object permanence (which is a cognitive skill that develops toward the end of infancy, according to Piaget's cognitive theory—more on that theory in the next module).

Stage theories hold that the sequence of development is universal. For example, in cross-cultural studies of language development, children from around the world reach language milestones in a similar sequence (Gleitman & Newport, 1995). Infants in all cultures coo before they babble. They begin babbling at about the same age and utter their first word around 12 months old. Yet we live in diverse contexts that have a unique effect on each of us. For example, researchers once believed that motor development followed one course for all children regardless of culture. However, childcare practices vary by culture, and different practices have been found to accelerate or inhibit the achievement of developmental milestones such as sitting, crawling, and walking (Karasik, Adolph, Tamis-LeMonda, & Bornstein, 2010).

For instance, let's look at the Aché society in Paraguay. They spend a significant amount of time foraging in forests. While foraging, Aché mothers carry their young children, rarely putting them down in order to protect them from getting hurt in the forest. Consequently, their children walk much later: They walk around 23–25 months old, in comparison to infants in Western cultures who begin to walk around 12 months old. However, as Aché children become older, they are allowed more freedom to move about, and by about age 9, their motor skills surpass those of U.S. children of the same age: Aché children are able to climb trees up to 25 feet tall and use machetes to chop their way through the forest (Kaplan & Dove, 1987). As you can see, our development is influenced by multiple

contexts, so the timing of basic motor functions may vary across cultures. However, the functions are present in all societies.

## Periods of Human Development

Think about the lifespan and make a list of what you would consider the basic periods of development. How many periods or stages are on your list? Perhaps you have three: childhood, adulthood, and old age. Or maybe four: infancy, childhood, adolescence, and adulthood. Developmentalists often break the lifespan into eight stages:

1. Prenatal Development
2. Infancy and Toddlerhood
3. Early Childhood
4. Middle Childhood
5. Adolescence
6. Early Adulthood
7. Middle Adulthood
8. Late Adulthood

In addition, the topic of “Death and Dying” is usually addressed after late adulthood since overall, the likelihood of dying increases in later life (though individual and group variations exist). Death and dying will be the topic of our last module, though it is not necessarily a stage of development that occurs at a particular age.

The list of the periods of development reflects unique aspects of the various stages of childhood and adulthood that will be explored in

this book, including physical, cognitive, and psychosocial changes. So while both an 8-month-old and an 8-year-old are considered children, they have very different motor abilities, cognitive skills, and social relationships. Their nutritional needs are different, and their primary psychological concerns are also distinctive. The same is true of an 18-year-old and an 80-year-old, both considered adults. We will discover the distinctions between being 28 or 48 as well. But first, here is a brief overview of the stages.

## Prenatal Development

Conception occurs and development begins. There are three stages of prenatal development: germinal, embryonic, and fetal periods. All of the major structures of the body are forming and the health of the mother is of primary concern. There are various approaches to labor, delivery, and childbirth, with potential complications of pregnancy and delivery, as well as risks and complications with newborns, but also advances in tests, technology, and medicine. The influences of nature (e.g., genetics) and nurture (e.g., nutrition and teratogens, which are environmental factors during pregnancy that can lead to birth defects) are evident. Evolutionary psychology, along with studies of twins and adoptions, help us understand the interplay of factors and the relative influences of nature and nurture on human development.

## Infancy and Toddlerhood

The first year and a half to two years of life are ones of dramatic growth and change. A newborn, with many involuntary reflexes and a keen sense of hearing but poor vision, is transformed into a walking, talking toddler within a relatively short period of time. Caregivers similarly transform their roles from those who

manage feeding and sleep schedules to constantly moving guides and safety inspectors for mobile, energetic children. Brain development happens at a remarkable rate, as does physical growth and language development. Infants have their own temperaments and approaches to play. Interactions with primary caregivers (and others) undergo changes influenced by possible separation anxiety and the development of attachment styles. Social and cultural issues center around breastfeeding or formula-feeding, sleeping in cribs or in the bed with parents, toilet training, and whether or not to get vaccinations.

## Early Childhood

Early childhood is also referred to as the preschool years, consisting of the years that follow toddlerhood and precede formal schooling, roughly from around ages 2 to 5 or 6. As a preschooler, the child is busy learning language (with amazing growth in vocabulary), is gaining a sense of self and greater independence, and is beginning to learn the workings of the physical world. This knowledge does not come quickly, however, and preschoolers may initially have interesting conceptions of size, time, space and distance, such as demonstrating how long something will take by holding out their two index fingers several inches apart. A toddler's fierce determination to do something may give way to a four-year-old's sense of guilt for doing something that brings the disapproval of others.

## Middle Childhood

The ages of 6-11 comprise middle childhood and much of what children experience at this age is connected to their involvement in the early grades of school. Now the world becomes one of learning and testing new academic skills and assessing one's abilities and accomplishments by making comparisons between self and

others. Schools participate in this process by comparing students and making these comparisons public through team sports, test scores, and other forms of recognition. The brain reaches its adult size around age seven, but it continues to develop. Growth rates slow down and children are able to refine their motor skills at this point in life. Children also begin to learn about social relationships beyond the family through interaction with friends and fellow students; same-sex friendships are particularly salient during this period.

The theory of psychosocial development created by Erik Erikson is one of the best-known personality theories. The theory differs from many others in that it addresses development across the entire lifespan, from birth through death.

At each stage, the individual deals with a conflict that serves as a turning point in development. When the conflict is resolved successfully, the person is able to develop the psychosocial quality associated with that particular stage of development. Learn about each psychosocial stage, including the conflict confronted and the major events that occur during each point of development.

**Stage 1: Trust Versus Mistrust**

Trust versus mistrust is the earliest psychosocial stage that occurs during the first year or so of a child's life. During this critical phase of development, an infant is utterly dependent upon his or her caregivers. When parents or caregivers respond to a child's needs in a consistent and caring manner, the child then learns to trust the world and the people around him.

**Stage 2: Autonomy Versus Shame and Doubt**

The second psychosocial stage involves the conflict between autonomy and shame or doubt. As the child enters the toddler years, gaining a greater sense of personal control becomes increasingly important. Tasks such as learning how to use the toilet, selecting foods and choosing toys are ways that children gain a greater sense of independence.

### Stage 3: Initiative Versus Guilt

The third psychosocial stage is known as initiative versus guilt and occurs between the ages of about three and five. This stage is centered on developing a sense of self-initiative. Children who are allowed and encouraged to engage in self-directed play emerge with a sense of strong initiative, while those who are discouraged may begin to feel a sense of guilt over their self-initiated activities.

### Stage 4: Industry Versus Inferiority

During middle childhood between the ages of about six and eleven, children enter the psychosocial stage known as industry versus inferiority. As children engage in social interaction with friends and academic activities at school, they begin to develop a sense of pride and accomplishment in their work and abilities.

Children who are praised and encouraged to develop a sense of competence. Those who are discouraged are left with a sense of inferiority.

### Stage 5: Identity Versus Confusion

In the fifth psychosocial stage is centered on identity versus role confusion. At this point in development, the formation of a personal identity becomes critical. During adolescence, teens explore different behaviors, roles, and identities.

Erikson believed that this stage was particularly crucial and that forging a strong identity serves as a basis for finding future direction in life. Those who find a sense of identity feel secure, independent and ready to face the future, while those who remain confused may feel lost, insecure and unsure of their place in the world.

## Successful aging

ne of the major achievements of medical science over the last few centuries is an extension of life expectancy. Historically, almost all religions practices have valued long life. Some of the religions emphasize disengagement/detachment in the old age as frailty becomes inevitable. However, till recent times, researchers did not discuss much about how best to live long life. Over the years, there is an emphasis on not just having for long only but also having disease-free long life.

Fortunately, the life expectancy has also increased in India. Compared to life expectancy of 32 years at the time of independence, it was estimated to be 65 years for the year 2011. Those aged >60 years formed 5.5% of the total population in 1951, which increased to 8.5% in 2011 and it is projected that by 2050, elderly will form 19% of the total population, with higher growth for those aged ≥80 years. However, should we be happy with increase in life expectancy and proportion of elderly only or should we focus on aging healthily. Unfortunately, there is no focus on healthy aging in India. In this editorial, an attempt is made to understand the concept of successful aging and in the end an attempt is made to understand the relevance to India.

In the Western world, before 1980s, much of the discussion in

relation to aging was on distinction between the pathological and nonpathological aging with focus on having or not having diseases or disabilities. The basic understanding was that those who were free from disease and disability, other age-related physical functions, and cognitive functions were normal, which was primarily determined by the genetic factors.

However, this concept was challenged, and one of the major concepts which have emerged over the last three decades or so is successful aging. In a landmark article, Rowe and Kahn

introduced the term successful aging and distinguished usual aging from "successful aging." They considered successful aging to include three main components, i.e., having low probability of disease and associated disability, high cognitive and physical functioning, and active engagement with life.

They further emphasized that successful aging does not merely involve the absence of disease or maintenance of functional capabilities, but requires combination of both along with active engagement with life. Thus, although maintenance of functional capacities and low risk for disease are very important, their combination with active engagement is considered central for defining successful aging. On the basis of this definition, research started in this area, and many authors evaluated the model of Rowe and Kahn

and it was soon realized that very few older people fulfilled all the three components of successful aging. Further, some of the researchers criticized the concept that the model of Rowe and Kahe

and suggested that the model downplayed the importance of genetics and species-determined deterioration of late life, did not lay emphasis on spirituality

and subjective well-being.

Further, it was suggested that from a life-span developmental perspective, successful aging model failed to address losses, gains, and balance in later life.

Over the years, many researchers developed their own model for and described different components of successful aging. In fact, the concept was also referred differently, i.e. the various synonymous terms used include positive aging, active aging, aging well, healthy aging, optimum aging, productive aging, vital aging, and robust aging. In recent decades, the most popular term in the United States has been successful aging and that in Europe has been active aging.

There is no universally accepted definition of successful aging. In fact, in a review of quantitative studies on successful aging in 2006, it was reported that there were at least 29 different definitions of the concept and most of these definitions focused on physical health.

The various components considered by these definitions include disability/physical functioning (26 definitions), cognitive functioning (13 definitions), life satisfaction/well-being (9 definitions), social/productive engagement (8 definitions), presence of illness (6 definitions), longevity (4 definitions), self-rated health (3 definitions), personality (2 definitions), environment/finances (2 definitions), and self-rated successful aging (2 definitions). Based on the definition, the prevalence of successful agers in different studies ranged from 0.4% to 95%.

In a systematic review of lay perspectives of successful ageing, three components, i.e., biomedical (physical functioning/disability, cognitive functioning/disability, affective status, presence/probability of disease, mental health, and longevity), psychosocial (personal resources, engagement, life satisfaction/well-being, support system, and independence/autonomy), and extrinsic factors (environment, finances-income, and financial security) were identified.

The authors reported that from lay perspective psychosocial components, notably engagement (e.g., social engagement), and personal resources (e.g., attitude) are the important components of successful aging, more often than "physiological" components, such as longevity or physical functioning.

## Theories of development: Psychoanalytical

When child development experts talk about the study of development, they have in mind some fundamental theories of development that were codified by brilliant clinicians and scientists well before we had the technology to correlate them to brain development.

In this post, we'll pay homage to these theorists. After all, every clinician who works with kids routinely and almost reflexively thinks of these scholars. The irony is that the theories are so pervasive and useful, that often the beginnings of these theories are lost in the story. Understanding how these theories came into being can therefore help to direct therapists and parents when they're deciding how best to understand their children.

Roughly speaking, these theories can be categorized as emotional, cognitive and moral. Erik Erikson developed the most common

theories of emotional development. Jean Piaget developed the most common theories of cognitive development. And, Lawrence Kohlberg developed the dominant theories of moral development.

Let's look at Erikson first.

Erikson saw the world as a series of age-matched developmental crises, and he conceptualized these crises as binary and competing values. He didn't think of the crises as bad things; rather, each crisis represented an opportunity to move forward.

Infancy, for example, is characterized by *Trust* (a positive value) versus *Mistrust* (a negative value). Adolescence is a battle between *Identity Formation* (good) versus *Role Diffusion* (bad). According to Erickson, if these binary crises are not successfully negotiated—if an infant, for instance, can't trust the adults of the world to keep him warm and fed and held—then that infant will grow up with a fundamental lack of trust, and at some point, will have to actively address this issue. These ideas actually stem directly from the psychoanalytic notions that Sigmund Freud put on the map, namely that past experience influences future feelings and behaviors. Erickson studied children and adults, and he characterized each stage of development as follows:

**Hope**: Trust vs. Mistrust (2 years)

**Will**: Autonomy vs. Shame & Doubt (2-4 years)

**Purpose**: Initiative vs. Guilt (Preschool, 4-5 years)

**Competence**: Industry vs. Inferiority (5-12 years)

**Fidelity**: Identity vs. Role Confusion (13-19 years)

**Love**: Intimacy vs. Isolation (20-40 years)

**Care**: Generativity vs. Stagnation (40-64 years)

**Wisdom**: Ego Integrity vs. Despair (65-death)

You can see from the bold print that Erickson associated certain personality characteristics with successful passage through these crises. He called these characteristics *values*. The infant who can trust, develops hope; the young adult who can be intimate, develops the capacity to love. In this sense, Erickson created a mechanism by which different individuals can be developmentally assessed. The adult who feels ashamed is automatically thrown back to the age where she first experienced shame; as shame occurs at around age 2 to 4, Erickson would argue that the ashamed adult will more likely act like a toddler. And, an adult behaving like a toddler gets into more trouble. This helps to provide a roadmap for the clinician.

This way of looking at development has its critics. Many have argued that Erickson's theories are primarily Western, and as the world becomes more multi-cultural, one must be wary of the generalizations that Erickson's work might engender. Not all cultures, for example, view adolescence as a time for identity formation.

Gil Noam, an internationally-known developmental psychologist at Harvard, has noted as well that Erickson seemed to skip an important stage between the values of **competence** and **fidelity**. Noam notes that young adolescents, or middle school kids, are less concerned with who they are as individuals, and more with what group defines them—hence, the emphasis on popularity in middle school. Noam calls this the "Psychology of Belonging," and he has shown through numerous studies that young teens can be helped most by being made to feel that they belong.

Jean Piaget is the next theorist we'll discuss.

Piaget was more interested in how kids change the way they think about the world; that's why he is considered the father of cognitive development.

Piaget watched how kids figure things out. He noticed that when kids are teeny, they do lots of touching and tasting. From this, he decided that very young kids learn about their new world by doing simple experiments. What does that cat feel like? How does the side of the table taste? After that, he felt that children moved onto a more binary view of the world. He noticed that school-aged kids rarely abstract; in today's world, for example, four fouls is an out every single time in first grade. He decided, therefore, that young school-aged kids are focused primarily on a black-and -white view of the world.

But then he noticed that as that first grader moves through elementary school, her views of the world change; at first, four fouls is an out every single time. By second grade, four fouls is an out because those are the rules that are used to keep the game fun. By third grade, four fouls is an out, but that rule doesn't have to be; in fact, by third grade, lots of energy is used in discussing the possible variations in the rules.

By sixth grade, kids start to eschew the rules altogether. To heck with the rules, they say—*We make the rules.*

And just like that, Piaget noticed that with the onset of adolescence emerged the capacity to abstract. Think of the shift, in just six years, from "the rules are the rules because they're the rules," to "we make the rules."

Piaget categorized the way kids make sense of the world like this:

**Preoperational** (ages 2-7) – Lots of gray matter, much less white matter

**Concrete Operational** (ages 7-11) – White matter starts to connect in linear patterns

**Formal Operations** (ages 11+) – Gray matter decreases as white matter flowers

Of course, Piaget couldn't have made the notations you read above about the changes in gray and white matter; But, it turns out the Piaget's theories correlate exactly with the neurobiology that he didn't yet have the tools to understand when he was writing in the early part of the 20th century.

All of this helped to set the stage for Lawrence Kohlberg (he came after Erickson and Piaget, but actually worked directly with Erickson). Kohlberg decided that if kids move along their development both emotionally and cognitively, then they must also move forward morally.

## Psychoanalytic Theory

### Stages of Psychoanalytic Theory:

### i. Sigmund Freud's Psychosexual Stages:

Freud believed our most basic drive is the sex drive. If you believe that biologically speaking the goal of our lives is to pass on our genes, then you might agree with Freud that the sex drive is central to everything else. He outlined five stages in child and adolescent development, which he called psychosexual stages.

At each of these stages, sexual energy is invested in a different part of the body, and gratification of the urges associated with those areas of the body is particularly pleasurable. He labelled these stages the oral, anal, phallic, latency, and genital stages. He believed that the way in which gratification of urges is handled during each of these stages determines the nature of an adult's personality and character.

Disturbances in any of the stages can result in psychological disturbance in adulthood. We will describe these stages and Freud's ideas about the effects later in life if development daring these stages does not go well.

The oral stage lasts from birth to about 18 months of age. The zone of pleasure is the mouth. A baby for whom taking in food is not pleasurable might not survive. If you give a 6-month-old baby a toy, what is the first thing she is likely to do? Toy makers are aware that children are likely to put anything in their mouths and warn us against giving them toys with small parts that can cause choking.

Freud developed the idea that someone can get "stuck" or fixated in one of the first three psychosexual stages of early childhood. That person will then exhibit characteristics of that stage later in life. For example, an individual who is fixated in the oral stage may want to continue to try to satisfy his oral urges by overeating or smoking.

Many of us have some remnants of this stage as we chew on our fingers or pencils; however, a fixation is really only a concern when it interferes with adaptive functioning in some critical way.

The anal stage lasts from 18 months to 3 years. At this age the pleasure center moves to the anus, and issues of toilet training become central. Although many of us squirm to think of the anus as a pleasure center, we have only to listen to the "poopy talk" of

young children to see the hilarity it brings about. The task of the child at this age is to learn to control his bodily urges to conform to society's expectations.

A person who is fixated at this stage may become over controlled as an adult. Everything must be in its proper place to an extreme degree. Conversely, someone might become "anal explosive," creating "messes" wherever he goes.

The phallic stage lasts from 3 to 6 years of age. At this stage Freud believed that the paths followed by boys and girls diverge in ways that have been extremely controversial. We will first look at the path for boys. A boy's pleasure becomes focused on the penis. Many parents must patiently explain to their little boy that he cannot keep his hand in his pants while out in company.

Later during this stage the boy develops what Freud called the Oedipus complex, named after the character from Greek mythology that unknowingly killed his own father and married his mother. The boy focuses all his affections on his mother and becomes angry at his father, who stands in the way of the child's sole possession of her.

However, in the normal course of events, the boy becomes uncomfortable with this anger at his father. Rather than experiencing the anger, he projects the feeling onto his father and fears that his father is angry at him. In this stage when he is focused on his own penis, the retribution he imagines from his father is that he will cut off the boy's penis.

Consequently, the boy develops what Freud called castration anxiety. In order to avoid this fate, the boy gives up his dream of marrying his mother and decides to become like or identify with his

father. A man who does not resolve the Oedipus complex may become fixated in this stage.

He may find rivalry or competition with other men overwhelming, as he doubts his ability to measure up to others. He may also find it difficult to have intimate relations with women, as they remind him of forbidden impulses toward his mother.

For girls, the picture is much more complicated and controversial, even for therapists who practice psychoanalysis. In the phallic stage, Freud believed that girls come to believe that they once had a penis and that it was cut off, leaving them with penis envy. Girls go through a similar complex, called the Electra complex, in which they want to marry their fathers and do away with their mothers.

Freud believed that girls must learn to identify with their mothers, whom they see as damaged in the same way that they themselves are. The only way in which they will achieve a sense of wholeness is when they produce a penis by having a baby boy. Freud believed that girls must accept their passive, receptive nature and those who do not adequately resolve the Electra complex might try to overcome their feelings of inferiority by being too assertive and masculine.

The critique of Freud's view of female development has been fierce, even from the early days of the development of psychoanalytic theory. Female psychoanalysts have argued that this explanation of female development has more to do with a little boy's view of girls than the girl's view of herself.

They also have argued that boys and men are just as jealous of women's ability to give birth as girls are of a boy's penis. Feminist Gloria Steinem satirized Freud's treatment of women by proposing a

version of psychoanalytic theory developed by a fictional "Phyllis Freud," based on womb and breast envy rather than penis envy.

The latency stage occurs between 6 and 12 years of age. Latent means inactive, and Freud believed that during this time the sex drive goes underground. Children move from their fantasies in the phallic period of marrying their parent to a new realization that they must take the long road toward learning to become a grown-up.

The sex drive provides energy for the learning that must take place but is not expressed overtly. Children transfer their interest from parents to peers. At this age children who had cross-sex friendships often relinquish them as boys and girls learn the meaning of "cooties" and each sex professes disgust for the other.

This separation of the sexes begins to change at age 12, when young adolescents enter the genital stage. At this point, sexual energy is focused on the genital area, and true sexual interest occurs between peers.

### ii. Erik Erikson's Psychosocial Stages:

Many of the people who initially studied and worked with Freud have gone on to change psychoanalytic theory in significant ways. Erik Homburger Erikson is one of the most influential. Erikson focused more on issues of the ego rather than the id. Ego means "I" or "self," and Erikson's major focus was on the development of identity.

He described a series of stages based on issues that arise during the process of psychosocial development. Erikson describes psychosocial stages because these issues are rooted in social experiences that are typical of each stage of development rather than in sexual urges. At each age he believed that there is a central

conflict to be resolved and the way in which we resolve that conflict lays the groundwork for the next stages of our development.

For example, Erikson believed that infants have to establish trust in the world around them, while toddlers have to struggle with developing autonomy, or a level of independence from their parents.

The other important aspect of Erikson's theory is that he believed that development does not stop in adolescence. He went beyond Freud's stages to add three stages of adulthood. He was the first theorist to acknowledge that we continue to grow and develop throughout our lives.

**Modern Applications of Psychoanalytic Theory:**

Although psychoanalytic theory has been controversial, ideas that come from psychoanalytic theory are still very influential, particularly in relation to the study of the development of mental and emotional disorders, a field known as developmental psychopathology.

Many psychotherapists continue to use therapy that is designed to uncover inner conflicts from earlier life experiences, especially early trauma, as the basis for current psychological symptoms. A number of modern theories and therapeutic approaches also have their roots in concepts taken from psychoanalytic theory.

If you take advanced courses in psychology, you are likely to learn more about some of these approaches. Evidence from other types of research that follow the scientific method has yielded mixed results. Some ideas have been supported by research, and others have not.

Erikson's ideas about the effect of social experiences on the development of personality throughout the life span have remained an important influence in the field of child development. A number of

his ideas have influenced contemporary child care practices and our understanding of how development occurs as a series of interrelated experiences.

For instance, we urge new parents to be sensitive and responsive to their infants as a way to establish a sense of trust, as Erikson described. We better understand the challenge of adolescence when we see it as a struggle to establish a coherent sense of individual identity.

These concepts have also been used to help in the treatment of children with emotional disturbances by providing a framework for understanding the central issues to be dealt with at different ages.

## Behaviorist Approach

Behaviorism is a theory of learning which states all behaviors are learned through interaction with the environment through a process called conditioning. Thus, behavior is simply a response to environmental stimuli. Behaviorism is only concerned with observable stimulus-response behaviors, as they can be studied in a systematic and observable manner.

The behaviorist movement began in 1913 when John Watson wrote an article entitled 'Psychology as the behaviorist views it,' which set out a number of underlying assumptions regarding methodology and behavioral analysis:

**All behavior is learned from the environment:**

Behaviorism emphasizes the role of environmental factors in influencing behavior, to the near exclusion of innate or inherited factors. This amounts essentially to a focus on learning.

We learn new behavior through classical or operant conditioning (collectively known as 'learning theory').

Therefore, when born our mind is 'tabula rasa' (a blank slate).

**Psychology should be seen as a science:**

Theories need to be supported by empirical data obtained through careful and controlled observation and measurement of behavior. Watson (1913) stated that:

'Psychology as a behaviorist views it is a purely objective experimental branch of natural science. Its theoretical goal is … prediction and control.' (p. 158).

The components of a theory should be as simple as possible. Behaviorists propose the use of operational definitions (defining variables in terms of observable, measurable events).

Behaviorism is primarily concerned with observable behavior, as opposed to internal events like thinking and emotion:

While behaviorists often accept the existence of cognitions and emotions, they prefer not to study them as only observable (i.e., external) behavior can be objectively and scientifically measured.

Therefore, internal events, such as thinking should be explained through behavioral terms (or eliminated altogether).

There is little difference between the learning that takes place in humans and that in other animals:

There's no fundamental (qualitative) distinction between human and animal behavior. Therefore, research can be carried out on animals as well as humans (i.e., comparative psychology).

Consequently, rats and pigeons became the primary source of data for behaviorists, as their environments could be easily controlled.

**Behavior is the result of stimulus-response:**

All behavior, no matter how complex, can be reduced to a simple stimulus-response association). Watson described the purpose of psychology as:

'To predict, given the stimulus, what reaction will take place; or, given the reaction, state what the situation or stimulus is that has caused the reaction.' (1930, p. 11).

**Types of Behaviorism**

Historically, the most significant distinction between versions of behaviorism is that between Watson's original 'methodological behaviorism,' and forms of behaviorism later inspired by his work, known collectively as neobehaviorism (e.g., radical behaviorism).

**Methodological Behaviorism**

Watson's article *'Psychology as the behaviorist views it'* is often referred to as the 'behaviorist manifesto,' in which Watson (1913, p. 158) outlines the principles of all behaviorists:

'Psychology as the behaviorist views it is a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behavior. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness.

The behaviorist, in his efforts to get a unitary scheme of animal response, recognizes no dividing line between man and brute. The behavior of man, with all of its refinement and complexity, forms only a part of the behaviorist's total scheme of investigation'.

## Radical Behaviorism

Radical behaviorism was founded by B.F Skinner and agreed with the assumption of methodological behaviorism that the goal of psychology should be to predict and control behavior.

Skinner, like Watson, also recognized the role of internal mental events, and while he agreed such private events could not be used to explain behavior, he proposed they should be explained in the analysis of behavior.

Another important distinction between methodological and radical behaviorism concerns the extent to which environmental factors influence behavior. Watson's (1913) methodological behaviorism asserts the mind is tabula rasa (a blank slate) at birth.

In contrast, radical behaviorism accepts the view that organisms are born with innate behaviors, and thus recognizes the role of genes and biological components in behavior.

## The History of Behaviorism

- Pavlov (1897) published the results of an experiment on conditioning after originally studying digestion in dogs.
- Watson (1913) launches the behavioral school of psychology, publishing an article, *Psychology as the behaviorist views it*.
- Watson and Rayner (1920) conditioned an orphan called Albert B (aka Little Albert) to fear a white rat.

- Thorndike (1905) formalized the *Law of Effect*.
- Skinner (1936) wrote *The Behavior of Organisms* and introduced the concepts of operant conditioning and shaping.
- Clark Hull's (1943) *Principles of Behavior* was published.
- B.F. Skinner (1948) published *Walden Two*, in which he described a utopian society founded upon behaviorist principles.
- Journal of the *Experimental Analysis of Behavior* begun in 1958.
- Chomsky (1959) published his criticism of Skinner's behaviorism, "*Review of Verbal Behavior*."
- Bandura (1963) publishes a book called the *Social Leaning Theory and Personality development* which combines both cognitive and behavioral frameworks.
- B.F. Skinner (1971) published his book, *Beyond Freedom and Dignity*, where he argues that free will is an illusion.

**Cognitive Development**

Children grow and develop rapidly in their first five years across the four main areas of development. These areas are motor (physical), language and communication, cognitive and social/emotional.

Cognitive development means how children think, explore and figure things out. It is the development of knowledge, skills, problem solving and dispositions, which help children to think about and understand the world around them. Brain development is part of cognitive development.

As a parent, it is important to foster your child's cognitive development as soon as he/she is born because doing so provides the foundation for your child's success in school and later in life. For example, research shows that children who can distinguish sounds at six months of age are better at acquiring the skills for learning to read at four and five years of age.

To promote your child's cognitive development, it is important that you actively engage in quality interactions on a daily basis. Examples include:

- Talking with your baby and naming commonly used objects.
- Letting your baby explore toys and move about.
- Singing and reading to your baby.
- Exposing your toddler to books and puzzles.
- Expanding on your child's interests in specific learning activities. For example, your toddler might show an early interest in dinosaurs, so you can take him/her on a trip to the natural history museum to learn more about the time that these creatures roamed the earth.
- Answering your child’s “why” questions.

Another way that you can foster your child's cognitive development is to provide him/her with choices and prompt him/her to make thoughtful decisions. You should also allow your child to explore different ways of solving problems. While you may want to provide some gentle guidance and encouragement, allow your child some time to figure out things, like a new puzzle. This may require some patience on your part, but it will ultimately help him/her to learn.

## Sensory Motor Activities

The foundation of growth, development, and learning in a child starts with sensory and motor interaction with the world. The brain is built from the bottom up and this starts with movement and sensory exploration. Sensory stimulation and feedback drive the brain, but the motor system drives sensory stimulation—you can't have one without the other. This is at the core of everything we do at Brain Balance Achievement Centers. It is crucial to improve motor skills, sensory detection, and processing before any higher learning, behavioral or academic changes can truly happen.

### Motor Skills

In almost every case, children who have been assessed with a developmental deficit in one or more areas are the kids who struggle with learning or behavioral issues. Invariably, these kids are the ones with inadequately developed sensory and motor systems. We often see they are uncoordinated, clumsy, and awkward with their gait. Motor activities involve a number of different skills, including:

- Muscle tone, strength, and coordination
- Rhythm and timing
- Bilateral coordination
- Gross and fine-motor skills
- Primitive and postural reflexes
- Eye-muscle balance and coordination
- Vestibular balance and posture

### Sensory Skills

Much like underdeveloped motor skills, the same applies when there are atypical sensory deficits — smell, touch, vision, hearing, and balance. No sensory function works in isolation. All the senses are dependent on other sensory functions, which are dependent on a baseline and acceptable level of development. Engaging our senses is a powerful way to engage our brain. At BB we engage the senses:

- Smell
- Touch
- Vestibular (inner ear)
- Proprioception (the ability to know where one's body is in space)
- Balance and spatial perception

At Brain Balance Achievement Centers, we assess all of these skills with standardized and accepted testing and we quantify them by grade, age, or functional level. Our program then works to integrate sensory input and strengthen motor skills through the frequency and duration of activities.

## Sensory and Motor Development, Ages 1 to 12 Months

Sensory and motor development is the gradual process by which a child gains use and coordination of the large muscles of the legs, trunk, and arms, and the smaller muscles of the hands. A baby begins to experience new awareness through sight, touch, taste, smell, and hearing.

Babies' sensory and motor development generally follows a typical pattern:

- At 1 month of age, babies' neck muscles are not developed enough to support their heads for prolonged periods of time. Babies can lift their heads only briefly when lying on their stomachs. Limb movements are influenced by newborn reflexes, such as the startle reflex, which makes a baby throw out his or her arms and spread the fingers in response to a loud noise or other sudden, unexpected stimulus. By 6 weeks of age, newborn reflexes begin to fade and the baby's strength and coordination improve.
- By age 3 months, your baby can control his or her head movements. Put your baby on his or her tummy during awake periods and closely supervise. Allowing your baby to exercise and move in this position helps develop head and neck muscles. Around 4 months of age, babies gain control and balance in their head, neck, and trunk. Most babies can balance their heads for short periods when in a stable position. Around this same age, your baby starts playing with his or her hands and grasps your finger on purpose, rather than as a reflex.
- Between 4 and 6 months of age, babies' balance and movement dramatically improve as they gain use and coordination of large muscles. During this time, babies purposefully roll over and may be able to sit with their hands balancing them in front (tripod position). Reaching toward an object with both hands, babies may grasp at toys with their palms.
- Babies gain more control of their muscles between 6 and 9 months of age as the nervous system connections continue to form. By the 7th month, babies can see almost as well as an adult. Babies develop leg and trunk coordination, sit alone

steadily, and may crawl using both their hands and feet. Some babies even pull themselves up to a standing position, although the timing and sequence of these milestones vary widely.

- Between 9 months and 12 months of age, babies explore the world with all their senses. At the same time, they are developing more control over their hands and fingers and may be able to grab small objects with a forefinger and thumb. Most babies this age like to experience and explore objects through taste and texture, which prompts them to put almost anything they can into their mouths. The brain continues to grow, helping to refine control over the large muscles. By now, your baby will probably be able to crawl and stand. In these few months before babies begin to walk, they often spend hours "cruising" around the room holding on to furniture and other objects. Cruising develops muscles and coordination and gives your baby a chance to practice walking.
- Many toddlers start to walk around 9 to 15 months of age. Those first steps are possible because of changes that have taken place in the brain and the spinal cord.

## Language development

**Language**, be it spoken, signed, or written, has specific components: a lexicon and grammar. **Lexicon** refers to the words of a given language. Thus, lexicon is a language's vocabulary. **Grammar** refers to the set of rules that are used to convey meaning through the use of the lexicon (Fernández &

Cairns, 2011). For instance, English grammar dictates that most verbs receive an “-ed” at the end to indicate past tense.

Language development is the process by which children come to understand and communicate language during early childhood.

## Description

From birth up to the age of five, children develop language at a very rapid pace. The stages of language development are universal among humans. However, the age and the pace at which a child reaches each milestone of language development vary greatly among children. Thus, language development in an individual child must be compared with norms rather than with other individual children. In general girls develop language at a faster rate than boys. More than any other aspect of development, language development reflects the growth and maturation of the brain. After the age of five it becomes much more difficult for most children to learn language.

Receptive language development (the ability to comprehend language) usually develops faster than expressive language (the ability to communicate). Two different styles of language development are recognized. In referential language development, children first speak single words and then join words together, first into two-word sentences and then into three-word sentences. In expressive language development, children first speak in long unintelligible babbles that mimic the cadence and rhythm of adult speech. Most children use a combination these styles.

## Infancy

Language development begins before birth. Towards the end of pregnancy, a fetus begins to hear sounds and speech coming from

outside the mother's body. Infants are acutely attuned to the human voice and prefer it to other sounds. In particular they prefer the higher pitch characteristic of female voices. They also are very attentive to the human face, especially when the face is talking. Although crying is a child's primary means of communication at birth, language immediately begins to develop via repetition and imitation.

**Between birth and three months of age, most infants acquire the following abilities:**

- seem to recognize their mother's voice
- quiet down or smile when spoken to
- turn toward familiar voices and sounds
- make sounds indicating pleasure
- cry differently to express different needs
- grunt, chuckle, whimper, and gurgle
- begin to coo (repeating the same sounds frequently) in response to voices
- make vowel-like sounds such as "ooh" and "ah"

**Between three and six months, most infants can do the following:**

- turn their head toward a speaker
- watch a speaker's mouth movements
- respond to changes in a tone of voice
- make louder sounds including screeches

- vocalize excitement, pleasure, and displeasure
- cry differently out of **pain** or hunger
- laugh, squeal, and sigh
- sputter loudly and blow bubbles
- shape their mouths to change sounds
- vocalize different sounds for different needs
- communicate desires with gestures
- babble for attention
- mimic sounds, inflections, and gestures
- make many new sounds, including "p," "b," and "m," that may sound almost speech-like

The sounds and babblings of this stage of language development are identical in babies throughout the world, even among those who are profoundly deaf. Thus all babies are born with the capacity to learn any language. Social interaction determines which language they eventually learn.

Six to 12 months is a crucial age for receptive language development. Between six and nine months babies begin to do the following:

- search for sources of sound
- listen intently to speech and other sounds
- take an active interest in conversation even if it is not directed at them
- recognize "dada," "mama," "bye-bye"

- consistently respond to their names
- respond appropriately to friendly and angry tones
- express their moods by sound and body language
- **play** with sounds
- make long, more varied sounds
- babble random combinations of consonants and vowels
- babble in singsong with as many as 12 different sounds
- experiment with pitch, intonation, and volume
- use their tongues to change sounds
- repeat syllables
- imitate intonation and speech sounds

**Between nine and 12 months babies may begin to do the following:**

- listen when spoken to
- recognize words for common objects and names of **family** members
- respond to simple requests
- understand "no"
- understand gestures
- associate voices and names with people
- know their own names

- babble both short and long groups of sounds and two-to-three-syllable repeated sounds (The babble begins to have characteristic sounds of their native language.)
- use sounds other than crying to get attention
- use "mama" and "dada" for any person
- shout and scream
- repeat sounds
- use most consonant and vowel sounds
- practice inflections
- engage in much vocal play

**Toddlerhood**

During the second year of life language development proceeds at very different rates in different children. By the age of 12 months, most children use "mama/dada" appropriately. They add new words each month and temporarily lose words. Between 12 and 15 months children begin to do the following:

- recognize names
- understand and follow one-step directions
- laugh appropriately
- use four to six intelligible words, usually those starting with "b," "c," "d," and "g," although less than 20 percent of their language is comprehensible to outsiders
- use partial words
- gesture and speak "no"

- ask for help with gestures and sounds

**At 15 to 18 months of age children usually do the following:**

- understand "up," "down," "hot," "off"
- use 10 to 20 intelligible words, mostly nouns
- use complete words
- put two short words together to form sentences
- chatter and imitate, use some echolalia (repetitions of words and phrases)
- have 20 to 25 percent of their speech understood by outsiders

At 18 to 24 months of age toddlers come to understand that there are words for everything and their language development gains momentum. About 50 of a child's first words are universal: names of foods, animals, family members, **toys** vehicles, and clothing. Usually children first learn general nouns, such as "flower" instead of "dandelion," and they may overgeneralize words, such as calling all toys "balls." Some children learn words for social situations, greetings, and expressions of love more readily than others. At this age children usually have 20 to 50 intelligible words and can do the following:

- follow two-step directions
- point to parts of the body
- attempt multi-syllable words
- speak three-word sentences
- ask two-word questions

- enjoy challenge words such as "helicopter"
- hum and sing
- express pain verbally
- have 50 to 70 percent of their speech understood by outsiders

After several months of slower development, children often have a "word spurt" (an explosion of new words). Between the ages of two and 18 years, it is estimated that children add nine new words per day. Between two and three years of age children acquire:

- a 400-word vocabulary including names
- a word for most everything
- the use of pronouns
- three to five-word sentences
- the ability to describe what they just saw or experienced
- the use of the past tense and plurals
- names for body parts, colors, toys, people, and objects
- the ability to repeat rhymes, songs, and stories
- the ability to answer "what" questions

Children constantly produce sentences that they have not heard before, creating rather than imitating. This **creativity** is based on the general principles and rules of language that they have mastered. By the time a child is three years of age, most of a child's speech can be understood. However, like adults, children vary greatly in how much they choose to talk.

Preschool

**Three to four-year-olds usually can do the following:**

- understand most of what they hear
- converse
- have 900 to 1,000-word vocabularies, with verbs starting to predominate
- usually talk without repeating syllables or words
- use pronouns correctly
- use three to six-word sentences
- ask questions
- relate experiences and activities
- tell stories (Occasional **stuttering** and stammering is normal in preschoolers.)

**Language skills usually blossom between four and five years of age. Children of this age can do the following:**

- verbalize extensively
- communicate easily with other children and adults
- articulate most English sounds correctly
- know 1,500 to 2,500 words
- use detailed six to eight-word sentences
- can repeat four-syllable words
- use at least four prepositions
- tell stories that stay on topic

- can answer questions about stories

**School age**

At age five most children can do the following:

- follow three consecutive commands
- talk constantly
- ask innumerable questions
- use descriptive words and compound and complex sentences
- know all the vowels and consonants
- use generally correct grammar

Six-year-olds usually can correct their own grammar and mispronunciations. Most children double their vocabularies between six and eight years of age and begin reading at about age seven. A major leap in reading comprehension occurs at about nine. Ten-year-olds begin to understand figurative word meanings.

Adolescents generally speak in an adult manner, gaining language maturity throughout high school.

**Common problems**

**Language delay** is the most common **developmental delay** in children. There are many causes for language delay, both environmental and physical. About 60 percent of language delays in children under age three resolve spontaneously. Early intervention often helps other children to catch up to their age group.

Common circumstances that can result in language delay include:

- concentration on developing skills other than language

- siblings who are very close in age or older siblings who interpret for the younger child
- inadequate language stimulation and one-on-one attention
- bilingualism, in which a child's combined comprehension of two languages usually is equivalent to other children's comprehension of one language
- psychosocial deprivation

**Language delay can result from a variety of physical disorders, including the following:**

- mental retardation
- maturation delay (the slower-than-usual development of the speech centers of the brain), a common cause of late talking
- a hearing impairment
- a learning disability
- cerebral palsy
- autism (a developmental disorder in which, among other things, children do not use language or use it abnormally)
- congenital blindness, even in the absence of other neurological impairment
- Klinefelter syndrome, a disorder in which males are born with an extra X chromosome

**Brain damage or disorders of the central nervous system can cause the following:**

- receptive aphasia or receptive language disorder, a deficit in spoken language comprehension or in the ability to respond to spoken language
- expressive aphasia, an inability to speak or write despite normal language comprehension
- childhood apraxia of speech, in which a sound is substituted for the desired syllable or word

**Parental concerns**

Language development is enriched by verbal interactions with other children and adults. Parents and care-givers can have a significant impact on early language development. Studies have shown that children of talkative parents have twice the vocabulary as those of quiet parents. A study from the National Institute of Child Health and Human Development (NICHD) found that children in high-quality childcare environments have larger vocabularies and more complex language skills than children in lower-quality situations. In addition language-based interactions appear to increase a child's capacity to learn. Recommendations for encouraging language development in infants include:

- talking to them as much as possible and giving them opportunities to respond, perhaps with a smile; short periods of silence help teach the give-and-take of conversation
- talking to infants in a singsong, high-pitched speech, called "parentese" or "motherese" (This is a universal method for enhancing language development.)
- using one- or two-syllable words and two to three-word sentences

- using proper words rather than baby words
- speaking slowly, drawing-out vowels, and exaggerating main syllables
- avoiding pronouns and articles
- using animated gestures along with words
- addressing the baby by name
- talking about on-going activities
- asking questions
- singing songs
- commenting on sounds in the environment
- encouraging the baby to make vowel-like and consonant-vowel sounds such as "ma," "da," and "ba"
- repeating recognizable syllables and repeating words that contain the syllable

When babies reach six to 12 months-of-age, parents should play word games with them, label objects with words, and allow the baby to listen and participate in conversations. Parents of toddlers should do the following:

- talk to the child in simple sentences and ask questions
- expand on the toddler's single words
- use gestures that reinforce words
- put words to the child's gestures
- name colors

- count items
- gently repeat correctly any words that the child has mispronounced, rather than criticizing the child

Parents of two to three-year-olds should do the following:

- talk about what the child and parent are doing each day
- encourage the child to use new words
- repeat and expand on what the child says
- ask the child yes-or-no questions and questions that require a simple choice

(Table by GGS Information Services.)

| Language development | |
|---|---|
| **Age** | **Activity** |
| Two months | Cries, coos, and grunts. |
| Four months | Begins babbling. Makes most vowel sounds and |
| | about half of consonant |

| | |
|---|---|
| | sounds. |
| Six months | Vocalizes with intonation. Responds to own |
| name. | |
| Eight months | Combines syllables when babbling, such "Ba-ba." |
| Eleven months | Says one word (or fragment of a word) with |
| meaning. | |
| Twelve months | Says two or three words with meaning. Practices |
| | inflection, such as raising pitch of voice at the |

| | |
|---|---|
| | end of a question. |
| Eighteen months | Has a vocabulary between five and 20 words, |
| | mostly nouns. Repeats word or phrase over and |
| | over. May start to join two words together. |
| Two years | Has a vocabulary of 150–300 words. Uses I, me, |
| | and you. Uses at least two prepositions (in, on, |
| | under). Combines words in short sentences. |
| | About two-thirds of what |

| | |
|---|---|
| | is spoken is |
| understandable. | |
| Three years | Has a vocabulary of 900–1000 words. Uses more |
| | verbs, some past tenses, and some plural nouns. |
| | Easily handles three-word sentences. Can give |
| | own name, sex, and age. About 90% of speech is |
| understandable. | |
| Four years | Can use at least four prepositions. Can usually |

| | |
|---|---|
| | repeat words of four syllables. Knows some |
| | colors and numbers. Has most vowels and |
| | diphthongs and consonants p, b, m, w, and n |
| | established. Talks a lot and repeats often. |
| Five years | Can count to ten. Speech is completely |
| | understandable, although articulation might not |
| | be perfect. Should have all vowels and |

| | |
|---|---|
| | consonants m, p, b, h, w, k, g, t, d, n, ng, y. Can |
| | repeat sentences as long as nine words. Speech |
| | is mostly grammatically correct. |
| Six years | Should have all vowels and consonants listed |
| | above, has added, f, v, sh, zh, th, l. Should be able |
| | to tell a connected story about a picture. |
| Seven years | Should have consonants s–z, r, voiceless th, ch, |

| | |
|---|---|
| | wh, and soft g. Should be able to do simple |
| | reading and print many words. |
| Eight years | All speech sounds established. Carries on |
| | conversation at a more adult level. Can tell |
| | complicated stories of past events. Easily uses |
| | complex and compound sentences. Reads simple |
| | stories with ease and can write simple |
| compositions. | |

| | |
|---|---|
| **SOURCE :** Child Development Institute. 2004. http://www.childdevelopmentinfo.com. | |

- encourage the child to ask questions
- read books about familiar things, with pictures, rhymes, repetitive lines, and few words
- read favorite books repeatedly, allowing the child to join in with familiar words
- encourage the child to pretend to read
- not interrupt children when they are speaking

**Parents of four to six-year-olds should:**

- not speak until the child is fully attentive
- pause after speaking to give the child a chance to respond
- acknowledge, encourage, and praise speech
- introduce new words
- talk about spatial relationships and opposites
- introduce limericks, songs, and poems
- talk about the television programs that they watch
- encourage the child to give directions
- give their full attention when the child initiates a conversation

Parents of six to 12-year-olds should talk to the children, not at them, encourage conversation by asking questions that require

more than a yes-or-no answer, and listen attentively as the child recounts the day's activities.

Additional recommendations for parents and care-givers, by the American Academy of Pediatrics and others, include:

- talking at eye level with a child and supplementing words with body language, gestures, and facial expressions to enhance language comprehension
- talking in ways that catch a child's attention
- using language to comfort a child
- using correct pronunciations
- using expressive language to discuss objects, actions, and emotions
- playing with sounds and words
- labeling objects and actions with words
- providing objects and experiences to talk about
- choosing activities that promote language
- listening carefully to children and responding in ways that let them know that they have been understood, as well as encouraging further communication
- using complete sentences and adding detail to expand on what a child has said
- knowing when to remain silent
- reading to a child by six months of age at the latest

- encouraging children to ask questions and seek new information
- encouraging children to listen to and ask questions of each other

**Television viewing does not promote language development.**

**When to call the doctor**

Parents should call the pediatrician immediately if they suspect that their child may have a language delay or a hearing problem. Warning signs of language delay in toddlers include:

- avoiding eye contact
- neither understanding nor speaking words by 18 months of age
- difficulty learning nursery rhymes or simple songs
- not recognizing or labeling common objects
- inability to pay attention to a book or movie
- poor articulation, such that a parent cannot understand the child more than 50 percent of the time

**KEY TERMS**

**Apraxia** —Impairment of the ability to make purposeful movements, but not paralysis or loss of sensation.

**Expressive aphasia** —A developmental disorder in which a child has lower-than-normal proficiency in vocabulary, production of complex sentences, and word recall, although language comprehension is normal.

**Expressive language** —Communicating with language.

**Expressive language development** —A style of language development in which a child's babble mimics the cadence and rhythm of adult speech.

**Receptive aphasia** —A developmental disorder in which a child has difficulty comprehending spoken and written language.

**Receptive language** —The comprehension of language.

**Referential language development** —A style of language development in which a child first speaks single words and then joins words together into two- and three-word sentences.

## Emotional development

**Emotional development**, emergence of the experience, expression, understanding, and regulation of emotions from birth and the growth and change in these capacities throughout childhood, adolescence, and adulthood. The development of emotions occurs in conjunction with neural, cognitive, and behavioral development and emerges within a particular social and cultural context.

### Infancy

The expression of emotions during infancy promotes the transition from complete dependency to autonomy. The expression of interest promotes exploration and cognitive development. Social (intentional) smiles and other expressions of joy promote social interaction and healthy attachment relationships with primary caregivers. The expression of sadness encourages empathy and helping behaviour, and the expression of anger signals protest and

discomfort. Infants' unique tendency to experience and express particular emotions and the threshold for expressing those emotions is usually referred to as their temperament or characteristic emotionality.

Researchers generally agree that neonatal (nonintentional) smiles are present at birth and that social smiling and emotional expressions of interest appear as early as six weeks of age. By four to five months of age, infants selectively smile at familiar faces and at other infants, and their caregivers begin to share positive emotional exchanges with them.

Researchers disagree in their explanations of the development and time of emergence of discrete negative emotional expressions. Consistently with the view that infants express negative emotions in early infancy, scientists have shown that infants perceive and respond differentially to the negative emotional expressions (e.g., sadness, anger) of others by the age of four months.

During the second six months of life, as infants gain rudimentary cognitive and memory capacities, they begin to express particular emotions based on context. Emotions begin to emerge dynamically as the infant begins to take a more direct role in emotional exchanges with caregivers. The emotional bond with the caregiver is increasingly important, as infants seek support for exploration and look for signals of danger.

## Toddlerhood And Early Childhood

During the toddler period, in conjunction with rapid maturation of the frontal lobes and the limbic circuit in the brain, recognition of the self emerges. As a result, the toddler strives to become more independent, and the expression of anger and defiance increases in that struggle for autonomy. The ability to differentiate the self from

others also promotes basic empathetic behaviour and moral understanding. By the end of the second year of life, toddlers respond to negative signals from others, and they have specific emotional responses to their own negative actions. The emotions that emerge with a rudimentary conception of the self are often called self-conscious emotions and include shame, embarrassment, guilt, and pride. Some self-conscious emotions, such as pride and guilt, do not emerge until toddlers and young children have learned to conceptualize internalized standards of behaviour.

As children enter preschool, they begin to label their own emotions and rely on discourse about emotions within the family to facilitate their understanding of basic emotions. Young children first distinguish happiness from negative emotions and then begin to distinguish negative emotions such as sadness, anger, and fear from each other. They begin to recognize these emotions in facial expressions, and then, as they enter middle childhood, they begin to understand situational determinants of emotions. An understanding of emotional subjectivity also develops as children learn that what makes one child happy may not make another child feel the same way.

The emergence of emotional self-regulation is particularly important during early childhood and occurs in the context of family and peer relationships. Open expression of positive emotions and warm, supportive relationships between parents and children promote effective emotional self-regulation. On the other hand, frequent expression of negative emotions in the family and harsh, punitive disciplinary responses increase the experience of distressing and dysregulated emotions that may lead to psychopathology. Appropriate peer relationships characterized by shared play

activities are also important for the development of emotional regulation during early childhood. Children gain emotional understanding and the capacity for empathetic and helping behaviour from well-regulated emotional exchanges with peers.

## Middle And Late Childhood

During middle and late childhood, stable self-concepts based on the child's typical emotional experiences emerge. With the increased capacity for self-reflection, children gain an understanding of their self-conscious emotions. As a result, the consistent experience of patterns of self-conscious emotions has an impact on the child's self-concept. For example, the tendency to experience shame rather than guilt in response to negative transgressions affects the child's emergent self-esteem and may encourage a tendency to respond with aggression or violence.

Also during middle and late childhood, children begin to understand that a single situation or event can lead to the experience of multiple, mixed emotions. For example, older children understand that a goodbye party for a sibling who will leave for college is likely to be both a happy and a sad event for the child and his sibling. This capacity likely emerges with the cognitive capacity to understand multiple aspects of a situation, called decentration.

Children also learn emotional display rules as they progress through middle and late childhood. For example, a child learns to look happy even though she feels upset when a friend or family member gives her an undesirable gift. The use of display rules tends to increase as children begin to consider what consequences their actions may have for others. Display rules are used judiciously, and the likelihood of suppressing negative emotion depends on a number of

factors, including the child's gender, the likely recipients of the expression, the specific context, and the child's cultural milieu.

## Adolescence

With adolescence comes an additional struggle for autonomy and increased time spent with peers and less time spent with the family. Adolescents become less emotionally dependent on their parents, but this emotional autonomy often emerges after a period of conflict and increased experience of negative emotions. Young adolescents often experience more negative affect than younger children, but the negative affect often decreases during the high school years. However, girls often experience a longer period of elevated negative affect than boys. Adolescents tend to experience more extreme emotions, both negative and positive, than their parents even in response to the same event

## SMSC- Spiritual, Moral, Social and Cultural aspects of learning:

At its heart, SMSC is about relationships and attitudes. At Halton School we begin with the values projected by staff, pupils and governors, the interactions between people and the way they care for one another. This includes the quality of the physical environment, the range of opportunities provided by the school both within the curriculum and beyond it and the relationship developed by the school with the wider community.

Teachers seek to plan learning experiences that have relevance to the children, that will combine the awe and wonder of the world with practical skills to aid them in their daily lives.

Pupils' **spiritual development** is shown by their:

- Beliefs, religious or otherwise, which inform **their perspective on life** and their **interest in** and **respect** for **different people's feeling and values**
- Sense of **enjoyment** and **fascination** in learning about **themselves, others** and the **world around them**, including the intangible
- Use of **imagination** and **creativity** in their learning
- Willingness to **reflect** on their **experiences.**

**Pupils' moral development is shown by their:**

- Ability to **recognise** the difference between **right** and **wrong** and their readiness to **apply** this understanding **in their own lives**
- Understanding of the **consequences of their actions**
- **Interest in investigating**, and offering reasoned views about, **moral** and **ethical issues**

**Pupils' social development is shown by their:**

- **Use** of a range of **social skills** in **different contexts**, including **working** and **socialising** with pupils from **different backgrounds**
- **Willingness to participate** in a **variety of social settings**, **cooperating well with others** and being able to **resolve conflicts** effectively

- **Interest in**, and understanding of, the way **communities** and societies **function** at a variety of levels.

**Pupils' cultural development is shown by their:**

- Understanding and appreciation of the wide range of cultural influences that have shaped their own **heritage**
- **Willingness** to **participate** in, and **respond to** artistic, musical, sporting, mathematical, technological and scientific **opportunities**
- Interest in **exploring** and **respecting cultural diversity** and the extent to which they **understand**, **accept and respect diversity**, as shown by their **attitudes** towards **different religious, ethnic and socio-economic** groups in the **local, national and global communities**.

# What is Psychopathology: Concept, Mental Status Examination, Classification, Causes?

**Psychopathology: Concept, Mental Status Examination, Classification, Causes**

How do we currently define psychopathology? In short, this discipline can be understood as an in-depth study of problems related to mental health. Just like *pathology* is the study of the nature of disease (including causes, development, and outcomes), *psychopathology* is the study of the same concepts within the realm of mental health (or illness).

This study of mental illness can include a long list of elements: symptoms, behaviors, causes (genetics, biology, social, psychological), course, development, categorization, treatments, strategies, and more.

In this way, psychopathology is all about exploring problems related to mental health: how to understand them, how to classify them, and how to fix them. Because of this, the topic of psychopathology extends from research to treatment and covers every step in between. The better we can understand why a mental disorder develops, the easier it will be to find effective treatments.

## Signs of Psychopathology

Signs of psychopathology vary depending on the nature of the condition. Some of the signs that a person might be experiencing some form of psychopathology include:

- Changes in eating habits
- Changes in mood
- Excessive worry, anxiety, or fear
- Feelings of distress
- Inability to concentrate
- Irritability or anger

- Low energy or feelings of fatigue
- Sleep disruptions
- Thoughts of self-harm or suicide
- Trouble coping with daily life
- Withdrawal from activities and friends

## Diagnostic Systems

Professionals engaged in research and treatment of psychopathology must use systems to arrive at conclusions regarding the best course of action for treatment. These systems are used to classify what are considered mental health disorders.

Currently, the most widely used systems for classifying mental illness in the United States are the following.[2]

## Diagnostic and Statistical Manual of Mental Disorders (DSM)

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is created by the American Psychiatric Association (APA) as an assessment system for mental illness. The DSM-5 published in 2013 is the current edition and includes identifiable criteria that mental health professionals use to arrive at a specific diagnosis.[3]

The criteria and list of disorders sometimes change as new research emerges. Some examples of disorders listed in the DSM-5 include major depressive disorder, bipolar disorder, schizophrenia, paranoid personality disorder, and social anxiety disorder.

## International Classification of Diseases (ICD)

The ICD is a system similar to the DSM. Now in its eleventh version, the ICD was developed over a century ago and was taken over by

the World Health Organization (WHO) when it was founded in 1948. So, how does the ICD-11 differ from the DSM-5?

First, the ICD-11 is produced by a global agency (the World Health Organization), while the DSM-5 is produced by a national professional association (the American Psychiatric Association). The ICD-11 is approved by the World Health Assembly composed of health ministers from 193 WHO member countries.

Second, the goal of the ICD-11 is to reduce the burden of disease globally. It includes medical as well as mental health diagnoses. Third, the ICD-11 is freely available on the Internet. In contrast, the DSM must be purchased, and the American Psychiatric Association derives revenue from sales of the book and related products.

Beyond these standard systems for classifying mental disorders, there also exists a burgeoning area of research and theory that moves away from the checklist format of making diagnoses. Since it's possible to have symptoms of a mental illness but not meet the criteria for an official diagnosis, studies of descriptive psychopathology hold promise for a better system of understanding.

The RDoC is a research framework initiative by the National Institute of Mental Health (NIMH) based on translational research from areas such as neuroscience, genomics, and experimental psychology. In this way, the RDoC is involved in describing the signs and symptoms of psychopathology rather than grouping them into disorders as has been historically done with the DSM and ICD. The RDoC is primarily aimed at planning and funding research.

**Works In Psychopathology?**

Just as the scope of psychopathology is broad-ranging from research to treatment, so too is the list of types of professionals who tend to be involved in the field.

At the research level, you will find research psychologists, psychiatrists, neuroscientists, and others trying to make sense of the different manifestations of mental disorders seen in clinical practice.

At the clinical level, you will find many types of professionals attempting to apply the diagnostic systems that are in place to provide effective treatments to individuals living with psychopathology. These can include the following and more:

- Clinical psychologists
- Counselors
- Criminologists
- Marriage and family therapists
- Nurse practitioners
- Psychiatric nurses
- Psychiatrists
- Social workers
- Sociologists

## Identifying Psychopathology

How do psychologists and psychiatrists decide what extends beyond normal behavior to enter the territory of "psychopathology?" Psychiatric disorders can be conceptualized as referring to

problems in four areas: deviance, distress, dysfunction, and danger.[4]

For example, if you were experiencing symptoms of depression and went to see a psychiatrist, you would be assessed according to a list of symptoms (most likely those in the DSM-5):

- **Deviance** refers to thoughts, emotions, or behaviors that deviate from what is common or at odds with what is deemed acceptable in the society. In the case of depression, you might report thoughts of guilt or worthlessness that are not common among other people.
- **Distress** refers to negative feelings either felt within a person or that result in discomfort in others around that person. In the case of depression, you might report extreme feelings of distress over sadness or guilt.
- **Dysfunction** refers to the inability to achieve daily functions like going to work. In the case of depression, you might report that you can't get out of bed in the morning or that daily tasks take you much longer than they should.
- **Danger** refers to behavior that might put you or someone else at some type of detrimental risk. In the case of depression, this could include reporting that you are having thoughts of suicide or harming yourself.

In this way, you can see that the distinction between normal versus psychopathological behavior comes down to how issues are affecting you or the people around you. Often it is not until things come to a crisis point that a diagnosis is made when someone comes in contact with a medical or mental health professional.[5]

Causes

There is not a single cause for psychopathology. There a number of factors that can increase the risk of mental illness, including:

- Biological factors, including genes and brain chemistry
- Chronic medical conditions
- Family members with mental illness
- Feelings of isolation
- Lack of social support
- Substance or alcohol use
- Traumatic or stressful experiences

It is also important to realize that mental health can change over time. The Centers for Disease Control and Prevention (CDC) suggests that 50% of all people will be diagnosed with a mental illness at some point in their life.[6]

**Types**

Some of the different types of psychopathology include, but are not limited to:

- Anxiety disorders
- Bipolar disorders
- Depressive disorders
- Disruptive, impulse-control, and conduct disorders
- Dissociative disorders
- Eating disorders
- Neurocognitive disorders

- Neurodevelopmental disorders
- Obsessive-compulsive disorders
- Personality disorders
- Schizophrenia spectrum and other psychotic disorders
- Sleep disorders
- Somatic symptom disorders
- Trauma- and stressor-related disorders
- Substance-related disorders

**History of the Study of Mental Illness**

We've come a long way since the earliest beginnings of trying to make sense of mental illness. Although individuals with mental health issues still face stigma and a lack of understanding, things were very different in the past.

Hippocrates, the 4th century BC Greek physician, rejected the notion of evil spirits and argued instead that mental illness was a disease of the brain relating to imbalances of bodily humors, or chemicals in the body fluids. Around the same time, the philosopher Plato argued that mental distress involved issues of virtue, morality, and the soul.

If you lived in the 16th century with a mental health problem, chances are you would not have been treated very well. At that time, mental illness was often viewed from a religious or superstitious point of view. Accordingly, it was assumed that people demonstrating strange behavior must have been overtaken by evil spirits or demons. The cure? You might have been tortured to bring you back to sanity. If that didn't work? Execution.

Later, in the 19th century, interest surged in the role of childhood and trauma in the development of mental illness. Following on the heels of this era, Sigmund Freud introduced talk therapy to deal with these unresolved childhood issues.

As of the present day, our understanding of mental illness has broadened, and so, thankfully, have the available treatments.

**Psychopathology is a term which refers to either the study of mental illness or mental distress or the manifestation of behaviours and experiences which may be indicative of mental illness or psychological impairment.**

## Mental State Examination

Mental State Examination (MSE) is compared with physical examination as a reliable method of objective data investigation. There is a growing concern with psychiatric clinics, nosology, and the reliability of diagnostic interview methods as a source of valid diagnostic strategy. Efforts to achieve an international diagnosis protocol have been unsuccessful or polemical. This paper focuses on psychopathology, MSE, and mental function development within Brazilian psychiatry over the last few decades.

**Methods:** Searches, interviews, and narrative reviews were done to look for systematic ways in which to conduct MSE, mental functions, symptom clusters, orientations about data observation and records. Brazilian psychopathology textbooks were examined, if they provided access to consolidated knowledge on psychopathology examination.

**Results:** Sixteen textbooks were selected from a 49 year span. Descriptive psychopathology with phenomenological orientation was

the primary trend in the MSE. Concepts derived from different traditions, most lacking common terminology, suggested some divergence among authors. Recommendations for patient observation and how to collect objective data was clear, but MSE standardization efforts were missing. A detailed description of mental function abnormalities was the main MSE record strategy, without consensus about ways to summarize and record this data. In an examination summary, mental strata was divided into “mental functions,” and MSE subsets were frequent. All authors considered the following mental functions: consciousness, perception, thought, memory, attention, orientation, and volition.

**Discussion:** Psychiatric competence demands MSE proficiency. Official documents are not clear about performance and recording standards. MSE data was usually recorded through descriptive psychopathology. A shift from detailed descriptive findings, to an array of observed pathological elements, described through a mental function checklist was observed over time. Clinical practice and research guidelines should consider the development of reliable MSE practices; however, it has been neglected by modern psychiatry/neuroscience through the excessive emphasis on interview protocols. Better MSE practices, and the improvement of bedside skill in psychiatry are necessary and depend on the recovery of psychopathological debates and semiological reasoning, which will allow the return of phenomenology-oriented “observational” techniques.

In modern clinical medicine, a diagnosis is obtained through the crossover of symptoms, obtained by anamnesis or by a clinical interview, and signs of symptoms, obtained through a physical examination and laboratory or image tests (). The former is supposed to spark multiple hypotheses which the clinician then

further investigates by looking at patient's signs and symptoms. Semiology has been described in many textbooks as Porto () or Bates (), and was over time formalized as the paramount method of clinical examination in internal medicine.

Such standard foundational programs were made possible through Claude Bernard's experimental medicine (), confirmed by Alvan Feinstein one century later, whereby stating that recent clinical epidemiology belongs to the same epistemological strata (). The same method was implemented in most medical specialties, including psychiatry (). With regard to general medical practice, physical examination (PE), lab, and image procedures provide the standard method to gather objective information, which is then used to refine the previously elaborated hypothesis through the anamnesis/interview method. The very idea of a PE and semiology was strengthened by the transformations of modern medicine, and was consolidated with the Flexnerian reformation of medical schools , ).

Psychiatry has tried to take part in this agenda and match such standards (). Clinical interviews as a standard procedure for anamnesis in psychiatry, has been rigorously investigated. An extensive bibliography, concerning how to improve an examiners agreement about symptoms, and a rising consensus about the need for a minimal structure for better clinician reliability, is now evident (). Mental health practice often uses Mental State Examination (MSE) as an equivalent to PE from routine clinical examination and as a reliable method for objective data gathering , –), since PE and MSE are logically correlated. However, clinical interview/anamnesis is previous to, and also guides PE procedures and laboratory searches, but it is the core of the mental/psychic examination process and used predominately in most cases. However, the

interview is a narrative, history taking method, and not an objective sign gatherer tool.

The interview should be a narrative, recollection method, not an objective investigative tool. PE is consistently mentioned throughout almost all propaedeutical textbooks in medicine, with minimal, if not aesthetical, variations. MSE however has not achieved any international protocol or structured general tool, not even a minimal array of standard techniques and clinical report methods. Although MSEs widespread use as a PE correlative might not be suitable and may also be equivocated , ), it still universally used to gather data, objective information and evidence in mental health practice.

MSE was simultaneously developed in different regions of the world, influenced by philosophically-oriented ideas on psychopathology (). Many psychopathology textbooks have also been written in different languages, according to different traditions, which have resulted in vast variations in technique and nomenclature ). Nevertheless, mental semiology has been overlooked in most historiographical efforts, despite the importance of nosological history ).

In the last 30 years, new trends in the history of psychiatry in Brazil developed, but none has considered mental examination. Estellita-Lins attempted to emphasize the phenomenology of living space (espace vécu) in Jaspers Psychopathology Textbook and its vital role concerning signs, “evidence” and examination (). Cheniaux () reviewed some of the Brazilian, and even foreign textbooks about “descriptive psychopathology,” searching for conceptual regularity or terminological “uniformity” among authors, but MSE was not addressed. Viotti Daker worked on the main Brazilian textbook by Nobre de Melo, examining its psychopathological models (). Again, the MSE was not mentioned, but Melo's emphasis on fully

assessing the person, before evaluating the particular functions subdivision, is noteworthy.

There is an increasing concern related to clinics and nosology in psychiatry. This concern might be traced back to Nancy Andreassen's claim concerning the loss of psychopathological knowledge by younger psychiatrists, and to Parnas' Danish group that contested the validity of the schizophrenia nosologic construct in DSM/ICD, further extended to the unreliability of diagnostic interview methods with structured diagnostic questionnaires (). We should also mention Jacob's questioning of MSE training in India (), Aragona's interrogation about the collaboration of neuroscience in psychiatric diagnosis, among many others ). As Rodrigues and Banzato have stated, if a sound agreement concerning the “validity” of a concept in psychiatry had already been achieved, there would not be such confusion around it ).

We foresee epistemological issues concerning psychiatry and mental health care, that have not yet been resolved, as the importance of examination skills and training in the evidence-based era. These themes are not simply classificatory issues but are fundamental psychopathological efforts demanding a discussion concerning the diagnosis process in mental health and psychiatry.

This study deals with modern psychiatry from a historical perspective but addresses some clinical problems such as MSE, examination reporting, patient records and psychopathology teaching/transmission. A narrow comprehension of what evidence means may have been overlooked such as bedside skills and in particular phenomenological examining tradition (–). Maybe ongoing “taxonomic issues” and “classification wars” in psychiatry () are fair and useful, but we should also pinpoint some relevant matters that

concern the examination, clinical reasoning and the diagnostic process itself ).

Aiming to elucidate the origins, development, and methods of how MSE has been consolidated in Brazil, a review was carried out on the national literature.

## Methods

MSE still lacks proper categorization in MESH and DeCS, and the best results of descriptors or key word searches were related to standard clinical interviews, therefore unsuitable for systematic MSE research purposes. Textbooks are known to be the introductory means to access expert knowledge in the medical field as defined by Ludwig Fleck . It was then decided to consider textbooks on psychopathology as a primary reference, following a timeline based on its reference and contents. A backward reference search was carried out at the start of 2017, using the Universidade Federal do Rio de Janeiro Library System, to look for psychopathology textbooks written or edited by Brazilian authors (UFRJ, Rede Minerva).[1] The same search strategy was extended to main bookstore digital systems, and sites specialized in old or out of print editions, and finally to Google and Google Scholar. The main search string used was “psicopatologia” or “psiquiatria.”

## Results

An initial list of 35 textbooks was selected. Among them were textbooks translated into Portuguese, not edited or written by Brazilian authors, and which were therefore excluded. Other books without any relevant chapters on MSE were also excluded. Twelve textbooks were finally chosen for the present study. The original list of books found and selected are presented in , . Whenever possible, the first and last edition of each book was consulted, and

discussions about systematic ways to conduct MSE, the ordering of MSE topics (distinct functions), orientations about data gathering and registration, definitions about “mental functions” and its levels, symptom clusters, groupings and set organization, were studied. Referenced articles and books citations were also checked. In older textbooks, terms and notions that are semantically related to MSE have changed over time. Therefore, any mention of a mental examination that clearly described careful mental observation techniques or descriptions was considered as similar or equivalent to MSE.

**TABLE 1**

**Table 1.** Textbook set with editions, publication years, and the 12 titles (in bold) chosen for investigation of MSE.

**TABLE 2**

**Table 2.** MSE in the investigated textbooks, number of items, how it is named, and their items or assessed functions.

A comprehensive review was carried out on Brazilian authors, researchers and literature, focusing on different MSE traditions, describing its various approaches and MSE segmentation around psychic functions. The list of discrete elements assembled into MSE was studied in detail. A structured method to register significant psychopathological abnormalities/anomalies through examinations did show up in the search results. It was identified as “súmula psicopatológica” (psychopathological summary) in some textbooks.

The works examined spanned over the last 49 years. The books were written mostly by psychiatrists with clinical expertise, working as University Professors or lecturers. Most publications were designed to teach psychopathology to medical doctors being trained

as a resident/internist in psychiatry. No MSE standard was identified, even though every author confirmed its relevance and consistency.

Most authors provided orientations on how to proceed with a careful patient observation during an interview, aimed at obtaining objective data. The most referred method, to organize and register MSE, consistently cited by some authors, was descriptive psychopathology with a phenomenological orientation. Textbooks agreed and actively encouraged a very detailed description of observed mental functions as the best way to record MSE. Additionally, there was no agreement on how to summarize its components (–, –).

Throughout the time span studied, MSE was not the standard term used to refer to psychic examination and was first adopted in 2000 in the Brazilian psychopathology and semiology textbook by Paulo Dalgalarrondo (), after which it was consistently used. It remains unclear if the term was chosen because of evidence-based efforts on examination, or if it represents a particular tradition. Regardless, Luiz Salvador de Miranda Sá Jr mentioned “mental examination,” an expression semantically related (), and Elias Paim called it “psychic examination” around 1976, as did Leme Lopes in about 1980 (, ). The only author that did not use MSE after 2000 was Claudio Lyra Bastos, who still mentioned “Psychic Examination” ().

All authors used subdivisions to analyze and describe MSE, but each provided a specific set. Even though there was a clear consensus that consciousness could only be artificially fragmented for didactic purposes, no agreement, convergence or discussion about the nature or number of necessary items could be identified. The theoretical basis underlying the operating subdivisions is therefore lacking. It remains unclear how these mental strata turned

into a divided set of “mental functions.” shows the items that form MSE, according to each author.

A concise examination summary through “súmula psicopatológica” was mentioned by only four authors (. It was not possible to track the origins of this notion, since the authors did not mentioned or contextualize it. Some hypothesis is developed through discussion.

It is noteworthy that among the initial textbook list, some belonged to a field aimed at researching psychotherapy and psychoanalysis—therefore promoting a broader signification of psychopathology. Although these books were not included, and considering that psychoanalytic psychopathology is different from descriptive psychopathology, it probably suggests that psychoanalysis has had some influence in Brazilian psychiatric practices, perhaps in a slightly different way than what occurred in the United States (, , ). The term “interview” has widespread use when referring to the diagnostic and therapeutic encounter with patients, including psychoanalytical sessions, which may add further confusion when searching for Psychiatric methods of MSE using indexed expressions, and which justifies the frequency of these textbooks in the initial search sample. A better evaluation of such influence would be desirable, but it is out of the scope of this paper.

## Discussion

Mental Health as a Brazilian tradition started in the nineteenth-century, after the creation of the hospice, by a Portuguese emperor (). It was not before the beginning of 1900, however, that academic psychiatry began to thrive, particularly after studies published by Juliano Moreira, Ulisses Pernambucano, followed by studies on forensic psychiatry published by Nina Rodrigues and Franco da Rocha psychiatry

The first psychopathology textbook edited by a Brazilian author was published by Isaías Paim at the very end of the 1960s as far as we were able to trace. Paim's textbook stresses that psychopathology is not a psychiatric “tool,” but an entirely different “science,” that could be applied by psychiatrists to comprehend and investigate mental illness Influenced by German and French authors, Paim thoroughly recommended detailed observations and descriptions of subjective reports and behaviors as the best way to register and carry out psychic examination

. This coupling of observation and description was continually reinforced by most authors analyzed ,

The vast majority of textbooks considered MSE with clear subdivisions, except Paim's) Psychiatry Treatise. The number of partitions ranged from 6 up to 18 items The first time they are referred to as “Mental Functions” in our textbook sample was in Dalagalarrondo's “Psicopatologia e Semiologia” Despite considerable variations in mental function descriptions and items adopted, all authors have explicitly considered the following mental functions: consciousness, perception, thought (not frequently comprising its 3-fold structure—Flow, Process, and content/Beliefs), memory, attention, orientation, and volition. Paim did not list mental functions in his treatise but had openly used it in his 1969 psychopathology textbook. These conceptual developments in Brazilian psychopathology call for further studies. We considered them as hints at the importance of mental function fragmentation and structure in psychopathology.

It was not possible to identify how subdivisions were adopted or created according to Brazilian textbooks. The lack of theoretical background may be responsible for the significant variation observed. Dividing or stratifying MSE seems to be the best method

to analyze and to conveniently engage in description efforts, to evaluate psychic life. A discussion concerning ways to split MSE for adequate observation and educational purposes is out of the scope of the present review, but highly desirable. Since there are no globally standardized guidelines on psychopathology training (), bedside examination skills must be regarded seriously, as an asset worth further exploring.

This chronologically considered textbook series, suggests that the first Brazilian authors that wrote about psychopathology—Nobre de Melo, () and Isaías Paim, ()—did not aim to or were not used to describe MSE as mental function subdivisions, but were eager to build long and meticulous reports of observed behavior, through a personal interaction with patients. Contemporary Brazilian authors however usually mention clear descriptions of mental function subdivisions, setting standards on how to study MSE and how to describe it. It was not possible to identify a “standard” MSE organization, although a written description of all that is observed is consistent in both older and recent textbooks .

We could not identify any efforts aimed toward comparative clinical psychopathology.

The origins of the clinical resume called “súmula psicopatológica” could not be identified. It may have a forensic and juridical background, as its etymology suggests. Besides lawsuit writing rights, there were many other compulsory examination practices that the Brazilian and then the eugenics Constitution (1937) recommended. Psychiatrists were accountable for defining a person's state of mental health in many common judiciary cases such as criminal subjects, couples before marriage, institutionalized children, among others. For instance, forensic demands synthesis during a long diagnostic process and extensive judicial records.

Some leading psychiatrists, such as Franco da Rocha were very fond of this reporting procedure after clinical examination. A historiographic article, reviewing old patient files, depicts an explicit use of “súmula” by psychiatrists when writing down their patient's observations around 1929. It is then possible to affirm that the use of “súmula” as the name given to the set of observed signs and symptoms in psychiatric interview was already widespread in Brazilian psychiatry by the early twenties.

Within the textbook set investigated, the first register of the word “súmula”—as a concise list of mental function subdivisions, containing psychopathological disturbances, observed through MSE—appears in Dalgalarrondo's textbook . The term “súmula psicopatológica” was also mentioned in Cheniaux psychopathology treatise. Cheniaux's communication, however, admitted that this precise notion had been in colloquial use since the early 90s, and declared that he was first introduced to it by prof Dr. Miguel Chalub, who also introduced him to categorized lists of mental functions with descriptive purposes[2].

Chalub, in turn, declared that he learned this exact expression from Professor José Leme Lopes, the chairman of UFRJ Psychiatric Institute in the seventies However, Leme Lopes' “Diagnoses in Psychiatry,” published in 1980 does not contain any mention of it (). Neither Chalub nor Cheniaux needed to trace its roots but acknowledged its common use in bedside practices. Both authors hypothesized that it was borrowed from international psychopathological tradition, and that it become mainstream through everyday use in many institutional facilities in Brazil. The same inference about the expression “mental function” might therefore be adopted.

Efforts to standardize medical examinations have been at the core of scientific experimental medicine. These attempts have branched alongside psychopathology developments. The systematization of diagnostic psychiatric interview has been considered a significant step toward the improvement of clinician reliability. However, doubts about the best way to use it clinically, still remains . Countries, like Denmark, have already regulated the use of at least one standard interview in clinical practice, for any diagnosis in psychiatry and others such as Australia use diagnostic tools in a mental health triage . These are anamnesis/interview standardized methods however, not MSE.

ICD and DSM contain examining tools (Schedules for Clinical Assessment in Neuropsychiatry—SCAN, Structured Clinical Interview for DSM-5 Disorders—SCID-5, Mini International Neuropsychiatric Interview—MINI) . OPCRIT is supposedly useful to organize MSE, although it seems vastly different from what is usually accepted in descriptive psychopathology, since it provides neither mental function subdivisions nor any coordinated step care to enhance MSE observation and description ). Nevertheless, the entire MSE procedure demands more than a structured interview, since it is not analogous to anamnesis, but correlated to the PE procedure. We suppose that MSE is not entirely congruent or wholly embedded in semi-structured interview protocols. Attempting to turn personal experiences into objective data is probably a source of unreliability between examiners, as previously described . As far as we know, there is no standard method or procedure for MSE.

Parnas argues that DSM-V and ICD-10 were constructed to avoid subjectivity, but its developers have not accomplished such intent . He emphasizes that it is easy to find objective, observable signs inside many diagnostic criteria, such as “blunt affect” in

schizophrenia or “fast speech” in mania. Such categories should have been avoided in a categorial diagnostic system based on a standard interview, that was developed to eliminate examiner opinion as a source of unreliability. In a standard interview, all diagnostic emphasis relies on a “yes” and “no” type series of questions, directed at the patient, who decides if a symptom is or is not present. If MSE categories were to be used in a categorial diagnostic system, it should provide a template MSE method to be followed by the examiner during practice. A list of valid abnormal psychopathological categories for classificatory issues should also be provided.

In Brazil, at least one recent official report, demands a careful description of MSE subdivisions into patient record files . The official document on psychiatric training in Brazil states that all candidates must be proficient on MSE skills (apply and record). Despite that, a standard MSE is not explicitly provided, and it is not clear how it should be done or registered . The Brazilian Association of Psychiatry (ABP), the professional body responsible for education, training, setting and raising standards in Brazilian Psychiatry, did not mention or provide any statements concerning MSE, until now (4th of May 2018).[3]

Since 2014, doctors that have experience in psychiatry or that have attended a psychiatry internship and desire to obtain a certificate in psychiatry must be submitted to a practical clinical examination test, in which they are observed while interviewing and examining a patient.[3] It is not evident in the documentation how the MSE, or even the clinical interview, would be assessed and what they are expected to perform during a practical examination test . The only clue provided is from Dalgalarrondo's textbook inclusion of

bibliographic references, which suggests that a detailed descriptive MSE and “súmula psicopatológica” is expected from candidates.

## Conclusion

Our research suggests that descriptive psychopathology seems to be the usual MSE method used to observe and record data, not much different from the European schools or other parts of the world . Seven mental functions were consistently identified in the selected textbooks (consciousness, perception, thought, memory, attention, orientation, and volition), however no standard MSE and mental functions set was found. It was possible to identify a shift from the semiological discussion in Brazil during the last 50 years, from a detailed descriptive routine observed during the patient interaction to an array of observed pathological elements described through a mental function checklist. The “súmula psicopatológica” appears to be one pattern of examination, which could be improved or updated. Ethnopsychiatry or transcultural psychiatry research is needed regarding MSE, to achieve a regional attunement with patients and to comprehend the MSE practice in general.

MSE altogether, with anamnesis or a clinical interview, provides the basis for psychiatric clinics and research. Good clinical exercise and research guidelines in psychiatry must include the development of reliable MSE practice; however, it seems to have been neglected by modern psychiatry and neuroscience. Stressing interview protocols might flatten examination skills and impoverish MSE abilities. Development of better MSE practices and the improvement of bedside skills in psychiatry rely on reviving the psychopathological debate and semiologic reasoning of a vibrant tradition, and allowing for the return to a phenomenology-oriented “observational” technique.

Since we are now dealing with knowledge that has almost become lost, the recovery of the history of psychiatry and of national/regional practices plays a paramount role in bringing previous experiences to the foreground, that could assist in the pursuit of this everlasting objective. In other words, the history of psychiatry plays a critical and hermeneutical role, and particular national attempts and enterprises in psychopathology should be re-evaluated. Practice standardization is now an international goal, but should not lead to one-way, top-down unification from high-tech oriented research centers, as global mental health policies have already advised. A call for diverse, multiple and manifold cultural experiences in MSE is necessary for the future development and improvement in Psychiatric practice and research.

## Limitations

This is a comprehensive review about Psychopathology Textbooks in Brazil and, although rigorous work has been done, it is possible that some critical publication is lacking due to methodological bias. Furthermore, because we dealt with vintage books, which have not yet been cataloged by electronic repositories, it is possible that old Brazilian Textbooks with some contradictory information were not found. Mainstream psychiatry has neglected psychiatric semiology, Mental State Examination, Mental Functions and its role in psychopathology standards and clinical practice, so it is possible that other authors have already answered the questions presented here, which was not picked up by our search strategy. This is a very complicated issue that needs to be addressed by a multi-professional team of linguists, anthropologist, science and medicine historians, and psychiatry practitioners. Further work may clarify and better elucidate these questions and issues.

## Classification of psychopathology: conceptual and historical background

While not all psychiatric disorders have such dramatic "avalanche-like" transitions, they are fairly common in clinical psychiatry and challenge the authors' conclusions that there is little viable evidence that psychiatric disorders need to be understood from a categorical perspective.

Let me turn to a quite different issue. I was concerned by the manner in which the authors characterize the DSM process: "group discussions and associated political processes", manifesting "sociopolitical dynamics", issuing *ex cathedra* decisions with the final diagnoses resulting from "presumed authority and fiat". This tone will not aid interdisciplinary discourse. The authors imply that they are the objective scientists while those who worked on DSM are, by comparison, bogged down in political discourse and constrained by old-fashioned historical dictates. While this is not the place to discuss this in detail, any organized effort in science to develop classifications involves "sociopolitical dynamics". Readers who think otherwise might consult a history of the decision of the International Astronomical Union to remove Pluto from the official list of planets

I want to conclude by talking about standards of diagnostic validation. At the risk of over-simplification, the Hierarchical Taxonomy of Psychopathology (HiTOP) program emphasizes psychometric methods in its typological proposals. Such methods have been key in the history of psychology, for example in the development of personality typologies and measures of various cognitive skills. So, it is sensible that they should be applied in the area of psychopathology. However, this approach differs considerably from the medical tradition emphasized by DSM. Put

simply, the medical tradition wants diagnoses that tell us a lot about the patient – the course, the likely etiologic process, the best treatment, etc.. We organize our literature around our diagnoses, from cohort studies to randomized controlled trials.

The specific articulation of this viewpoint in psychiatry was first given by Robins and Guze

with their list of validators, substantially expanded since then. Since DSM-III, the role of the evaluation of validators in diagnostic change has, albeit somewhat unevenly, gradually increased. The main approach has been the use of literature reviews trying to summarize available information on validators. These questions were the specific focus of the Scientific Review Committee that evaluated every proposed diagnostic change in DSM-56 The procedures developed for change in DSM-5 by the American Psychiatric Association's Steering Committee are empirically rigorous and data driven.

It is not surprising that the scientific disciplines of psychiatry and clinical psychology have developed different approaches to the creation and evaluation of diagnostic entities/dimensions. Optimal communication between these two disciplines, however, requires an understanding of the similarities and differences in these approaches, the relative strengths and limitations of each approach, and the acceptance by both sides that each is likely to be able to contribute meaningfully to the difficult challenge of designing an optimal psychiatric classification.

## THE INTERNATIONAL CLASSIFICATION OF DISEASES

A second classification system, the *International Classification of Diseases* (ICD), is also widely recognized. Published by the World Health Organization (WHO), the ICD was developed in Europe

shortly after World War II and, like the DSM, has been revised several times.

The categories of psychological disorders in both the DSM and ICD are similar, as are the criteria for specific disorders; however, some differences exist. Although the ICD is used for clinical purposes, this tool is also used to examine the general health of populations and to monitor the prevalence of diseases and other health problems internationally (WHO, 2013).

The ICD is in its 10th edition (ICD-10); however, efforts are now underway to develop a new edition (ICD-11) that, in conjunction with the changes in DSM-5, will help harmonize the two classification systems as much as possible (APA, 2013).

A study that compared the use of the two classification systems found that worldwide the ICD is more frequently used for clinical diagnosis, whereas the DSM is more valued for research (Mezzich, 2002). Most research findings concerning the etiology and treatment of psychological disorders are based on criteria set forth in the DSM (Oltmanns & Castonguay, 2013).

The DSM also includes more explicit disorder criteria, along with an extensive and helpful explanatory text (Regier et al., 2012). The DSM is the classification system of choice among U.S. mental health professionals, and this chapter is based on the DSM paradigm.

## THE COMPASSIONATE VIEW OF PSYCHOLOGICAL DISORDERS

As these disorders are outlined, please bear two things in mind. First, remember that psychological disorders represent *extremes* of inner experience and behavior. If, while reading about these

disorders, you feel that these descriptions begin to personally characterize you, do not worry—this moment of enlightenment probably means nothing more than you are normal.

Each of us experiences episodes of sadness, anxiety, and preoccupation with certain thoughts—times when we do not quite feel ourselves. These episodes should not be considered problematic unless the accompanying thoughts and behaviors become extreme and have a disruptive effect on one's life. Second, understand that people with psychological disorders are far more than just embodiments of their disorders.

We do not use terms such as schizophrenics, depressives, or phobics because they are labels that objectify people who suffer from these conditions, thus promoting biased and disparaging assumptions about them. It is important to remember that a psychological disorder is not what a person *is*; it is something that a person *has*—through no fault of his or her own. As is the case with cancer or diabetes, those with psychological disorders suffer debilitating, often painful conditions that are not of their own choosing. These individuals deserve to be viewed and treated with compassion, understanding, and dignity.

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# What is Psychotherapies: Psychoanalysis, Person-centered, Gestalt, Existential, Acceptance Commitment Therapy, Behavior therapy, REBT,

# CBT, MBCT, Play therapy, Positive psychotherapy, Transactional Analysis, Dialectic behavior therapy, Art therapy, Performing Art Therapy, Family therapy?

## Psychotherapies: Psychoanalysis, Person-centered, Gestalt, Existential

Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health provider.

During psychotherapy, you learn about your condition and your moods, feelings, thoughts and behaviors. Psychotherapy helps you learn how to take control of your life and respond to challenging situations with healthy coping skills.

There are many types of psychotherapy, each with its own approach. The type of psychotherapy that's right for you depends on your individual situation. Psychotherapy is also known as talk therapy, counseling, psychosocial therapy or, simply, therapy.

Why it's done

Psychotherapy can be helpful in treating most mental health problems, including:

- **Anxiety disorders,** such as obsessive-compulsive disorder (OCD), phobias, panic disorder or post-traumatic stress disorder (PTSD)
- **Mood disorders,** such as depression or bipolar disorder

- **Addictions,** such as alcoholism, drug dependence or compulsive gambling
- **Eating disorders,** such as anorexia or bulimia
- **Personality disorders,** such as borderline personality disorder or dependent personality disorder
- **Schizophrenia** or other disorders that cause detachment from reality (psychotic disorders)

Not everyone who benefits from psychotherapy is diagnosed with a mental illness. Psychotherapy can help with a number of life's stresses and conflicts that can affect anyone. For example, it may help you:

- **Resolve conflicts** with your partner or someone else in your life
- **Relieve anxiety or stress** due to work or other situations
- **Cope with major life changes,** such as divorce, the death of a loved one or the loss of a job
- **Learn to manage unhealthy reactions,** such as road rage or passive-aggressive behavior
- **Come to terms with an ongoing or serious physical health problem,** such as diabetes, cancer or long-term (chronic) pain
- **Recover from physical or sexual abuse** or witnessing violence
- **Cope with sexual problems,** whether they're due to a physical or psychological cause

- **Sleep better,** if you have trouble getting to sleep or staying asleep (insomnia)

In some cases, psychotherapy can be as effective as medications, such as antidepressants. However, depending on your specific situation, psychotherapy alone may not be enough to ease the symptoms of a mental health condition. You may also need medications or other treatments.

Risks

Generally, there's little risk in having psychotherapy. But because it can explore painful feelings and experiences, you may feel emotionally uncomfortable at times. However, any risks are minimized by working with a skilled therapist who can match the type and intensity of therapy with your needs.

The coping skills that you learn can help you manage and conquer negative feelings and fears.

How you prepare

Here's how to get started:

- **Find a therapist.** Get a referral from a doctor, health insurance plan, friend or other trusted source. Many employers offer counseling services or referrals through employee assistance programs (EAPs). Or you can find a therapist on your own, for instance, by looking for a professional association on the Internet.
- **Understand the costs.** If you have health insurance, find out what coverage it offers for psychotherapy. Some health plans cover only a certain number of psychotherapy sessions a year. Also, talk to your therapist about fees and payment options.

- **Review your concerns.** Before your first appointment, think about what issues you'd like to work on. While you also can sort this out with your therapist, having some sense in advance may provide a good starting point.

## Check qualifications

Before seeing a psychotherapist, check his or her background, education, certification, and licensing. Psychotherapist is a general term rather than a job title or indication of education, training or licensure.

Trained psychotherapists can have a number of different job titles, depending on their education and role. Most have a master's or doctoral degree with specific training in psychological counseling. Medical doctors who specialize in mental health (psychiatrists) can prescribe medications as well as provide psychotherapy.

Examples of psychotherapists include psychiatrists, psychologists, licensed professional counselors, licensed social workers, licensed marriage and family therapists, psychiatric nurses, or other licensed professionals with mental health training.

Make sure that the therapist you choose meets state certification and licensing requirements for his or her particular discipline. The key is to find a skilled therapist who can match the type and intensity of therapy with your needs.

What you can expect

## Your first therapy session

At the first psychotherapy session, the therapist typically gathers information about you and your needs. You may be asked to fill out forms about your current and past physical and emotional health. It

might take a few sessions for your therapist to fully understand your situation and concerns and to determine the best approach or course of action.

The first session is also an opportunity for you to interview your therapist to see if his or her approach and personality are going to work for you. Make sure you understand:

- What type of therapy will be used
- The goals of your treatment
- The length of each session
- How many therapy sessions you may need

Don't hesitate to ask questions anytime during your appointment. If you don't feel comfortable with the first psychotherapist you see, try someone else. Having a good fit with your therapist is critical for psychotherapy to be effective.

## Starting psychotherapy

You'll likely meet in your therapist's office or a clinic once a week or every other week for a session that lasts about 45 to 60 minutes. Psychotherapy, usually in a group session with a focus on safety and stabilization, also can take place in a hospital if you've been admitted for treatment.

## Types of psychotherapy

There are a number of effective types of psychotherapy. Some work better than others in treating certain disorders and conditions. In many cases, therapists use a combination of techniques. Your therapist will consider your particular situation and preferences to determine which approach may be best for you.

Although many types of therapies exist, some psychotherapy techniques proven to be effective include:

- **Cognitive behavioral therapy (CBT),** which helps you identify unhealthy, negative beliefs and behaviors and replace them with healthy, positive ones
- **Dialectical behavior therapy,** a type of CBT that teaches behavioral skills to help you handle stress, manage your emotions and improve your relationships with others
- **Acceptance and commitment therapy,** which helps you become aware of and accept your thoughts and feelings and commit to making changes, increasing your ability to cope with and adjust to situations
- **Psychodynamic and psychoanalysis therapies,** which focus on increasing your awareness of unconscious thoughts and behaviors, developing new insights into your motivations, and resolving conflicts
- **Interpersonal psychotherapy,** which focuses on addressing problems with your current relationships with other people to improve your interpersonal skills — how you relate to others, such as family, friends and colleagues
- **Supportive psychotherapy,** which reinforces your ability to cope with stress and difficult situations

Psychotherapy is offered in different formats, including individual, couple, family or group therapy sessions, and it can be effective for all age groups.

**During psychotherapy**

For most types of psychotherapy, your therapist encourages you to talk about your thoughts and feelings and what's troubling you. Don't worry if you find it hard to open up about your feelings. Your therapist can help you gain more confidence and comfort as time goes on.

Because psychotherapy sometimes involves intense emotional discussions, you may find yourself crying, upset or even having an angry outburst during a session. Some people may feel physically exhausted after a session. Your therapist is there to help you cope with such feelings and emotions.

Your therapist may ask you to do "homework" — activities or practices that build on what you learn during your regular therapy sessions. Over time, discussing your concerns can help improve your mood, change the way you think and feel about yourself, and improve your ability to cope with problems.

## Confidentiality

Except in rare and specific circumstances, conversations with your therapist are confidential. However, a therapist may break confidentiality if there is an immediate threat to safety (yours or someone else's) or when required by state or federal law to report concerns to authorities. Your therapist can answer questions about confidentiality.

## Length of psychotherapy

The number of psychotherapy sessions you need — as well as how frequently you need to see your therapist — depends on such factors as:

- Your particular mental illness or situation

- Severity of your symptoms
- How long you've had symptoms or have been dealing with your situation
- How quickly you make progress
- How much stress you're experiencing
- How much your mental health concerns interfere with day-to-day life
- How much support you receive from family members and others
- Cost and insurance limitations

It may take only weeks to help you cope with a short-term situation. Or, treatment may last a year or longer if you have a long-term mental illness or other long-term concerns.

Results

Psychotherapy may not cure your condition or make an unpleasant situation go away. But it can give you the power to cope in a healthy way and to feel better about yourself and your life.

**Getting the most out of psychotherapy**

Take steps to get the most out of your therapy and help make it a success.

- **Make sure you feel comfortable with your therapist.** If you don't, look for another therapist with whom you feel more at ease.
- **Approach therapy as a partnership.** Therapy is most effective when you're an active participant and share in

decision-making. Make sure you and your therapist agree about the major issues and how to tackle them. Together, you can set goals and measure progress over time.

- **Be open and honest.** Success depends on willingness to share your thoughts, feelings and experiences, and to consider new insights, ideas and ways of doing things. If you're reluctant to talk about certain issues because of painful emotions, embarrassment or fears about your therapist's reaction, let your therapist know.
- **Stick to your treatment plan.** If you feel down or lack motivation, it may be tempting to skip psychotherapy sessions. Doing so can disrupt your progress. Try to attend all sessions and to give some thought to what you want to discuss.
- **Don't expect instant results.** Working on emotional issues can be painful and may require hard work. You may need several sessions before you begin to see improvement.
- **Do your homework between sessions.** If your therapist asks you to document your thoughts in a journal or do other activities outside of your therapy sessions, follow through. These homework assignments can help you apply what you've learned in the therapy sessions to your life.
- **If psychotherapy isn't helping, talk to your therapist.** If you don't feel that you're benefiting from therapy after several sessions, talk to your therapist about it. You and your therapist may decide to make some changes or try a different approach that may be more effective.

## Psychoanalytic Psychotherapy

**Psychoanalytic or Psychodynamic Psychotherapy** is a form of clinical practice which is based on psychoanalytic theory and principles. It's a treatment modality that in many ways is quite similar to psychoanalysis, although often considered less intense. Psychoanalytic psychotherapy utilizes psychoanalytic theories as the frame for formulation and understanding of the therapy process. These multiple theories apply to the psychotherapy situation, with a focus on increasing self understanding and deepening insight into emotional issues and conflicts which underlie the presenting difficulties. Typically therapists make use of exploration of unconscious thoughts and feelings, understanding aspects of the relationship between therapist and patient, which may relate to underlying emotional conflicts, interpretation of defensive processes which obstruct emotional awareness, and consideration of issues related to sense of self and self esteem.

Most often therapy sessions occur between one and four times weekly. The focus is on exploration of the patient's inner experience, emphasizing this as it occurs in current daily life, as it carries over from significant and influential events and relationships of the past, and as it is manifest in the context of the therapeutic relationship.

The efficacy of psychoanalytic psychotherapy, often referred to as psychodynamic psychotherapy, has been well documented. Current research indicates this as a powerfully curative treatment. *P*

## Who is a Psychoanalytic Psychotherapist?

Clinicians who practice psychoanalytic or psychodynamic psychotherapy all share a common orientation about how to assess and treat emotional problems. Most psychodynamic therapists have extensive training. The formats and contexts of this training are wide

ranging – from graduate or medical school instruction and case supervision to **rigorous and formal** advanced psychotherapy training programs or psychoanalytic training. The vast majority of psychoanalytic psychotherapists elect to pursue ongoing additional training beyond their graduate or medical school instruction in order to deepen and extend their skills. Psychoanalytic psychotherapists can be found in a variety of professional disciplines, including social work, psychology, psychiatry, and psychiatric nursing.

**Who can benefit from Psychoanalytic Psychotherapy?**

While there is no simple answer to this question, it is important to emphasize that psychodynamic psychotherapy can be an effective treatment or component of a combined treatment for a very wide range of emotional and psychological difficulties. This includes, in one form or another all ages, and many diagnostic categories. The range of indications is significantly wider than that for psychoanalysis. In order to address this question for any individual, a careful evaluation with a well qualified therapist is an important first step.

## Person-Centered Therapy (Rogerian Therapy)

**Person-centered therapy** was developed by Carl Rogers in the 1940s. This type of therapy diverged from the traditional model of the therapist as expert and moved instead toward a nondirective, empathic approach that empowers and motivates the client in the therapeutic process. The therapy is based on Rogers's belief that every human being strives for and has the capacity to fulfill his or her own potential. Person-centered therapy, also known as Rogerian therapy, has had a tremendous impact on the field of psychotherapy and many other disciplines.

## ROGERIAN THEORY IN PSYCHOTHERAPY

Rather than viewing people as inherently flawed, with problematic behaviors and thoughts that require treatment, person-centered therapy identifies that each person has the capacity and desire for personal growth and change. Rogers termed this natural human inclination “actualizing tendency,” or self-actualization. He likened it to the way that other living organisms strive toward balance, order, and greater complexity. According to Rogers, "Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided."

The person-centered therapist learns to recognize and trust human potential, providing clients with empathy and unconditional positive regard to help facilitate change. The therapist avoids directing the course of therapy by following the client’s lead whenever possible. Instead, the therapist offers support, guidance, and structure so that the client can discover personalized solutions within themselves.

Person-centered therapy was at the forefront of the humanistic psychology movement, and it has influenced many therapeutic techniques and the mental health field, in general. Rogerian techniques have also influenced numerous other disciplines, from medicine to education.

## SIX FACTORS NECESSARY FOR GROWTH IN ROGERIAN THEORY

Rogers identified six key factors that stimulate growth within an individual. He suggested that when these conditions are met, the person will gravitate toward a constructive fulfillment of potential.

According to Rogerian theory, the six factors necessary for growth are:

1. **Therapist-Client Psychological Contact:** This first condition simply states that a relationship between therapist and client must exist in order for the client to achieve positive personal change. The following five factors are characteristics of the therapist-client relationship, and they may vary by degree.
2. **Client Incongruence or Vulnerability:** A discrepancy between the client's self-image and actual experience leaves him or her vulnerable to fears and anxieties. The client is often unaware of the incongruence.
3. **Therapist Congruence or Genuineness:** The therapist should be self-aware, genuine, and congruent. This does not imply that the therapist be a picture of perfection, but that he or she be true to him- or herself within the therapeutic relationship.
4. **Therapist Unconditional Positive Regard (UPR):** The clients' experiences, positive or negative, should be accepted by the therapist without any conditions or judgment. In this way, the client can share experiences without fear of being judged.
5. **Therapist Empathy:** The therapist demonstrates empathic understanding of the clients' experiences and recognizes emotional experiences without getting emotionally involved.
6. **Client Perception:** To some degree, the client perceives the therapist's unconditional positive regard and empathic understanding. This is communicated through the words and behaviors of the therapist.

## Gestalt Therapy

Gestalt therapy is a humanistic, holistic, person-centered form of psychotherapy that is focused on an individual's present life and challenges rather than delving into past experiences. This approach stresses the importance of understanding the context of a person's life and taking responsibility rather than placing blame.

It can be a little intimidating to consider starting therapy, especially if you imagine yourself sitting in the therapy room talking about the past. Although revisiting the past is an important part of identifying what needs to be healed, Gestalt therapy is an approach that focuses more on the "here and now" experience of the client.

Gestalt, by definition, refers to the form or shape of something and suggests that the whole is greater than the sum of its parts. There is an emphasis on perception in this particular theory of counseling. Gestalt therapy gives attention to how we place meaning and make sense of our world and our experiences.

Within Gestalt therapy, the client has space to safely explore their experiences without fear of judgment. In fact, the clients are encouraged to not simply talk about their emotions or experiences, but to bring them into the room so they can be processed in real-time with the therapist.

Gestalt therapy suggests that, inherently, people strive for self-regulation and growth. However, we sometimes develop techniques to emotionally survive unfortunate and painful experiences. Some of these techniques feel helpful in the short-term because they can help minimize our pain or distress. However, over the long-term,

they leave us is more emotionally shaky places, unable to express ourselves. We may find it hard to interact with others, and difficult to learn how to effectively regulate ourselves and be whole, responsible beings.

## Strengths and Weaknesses

Gestalt therapy has both some pluses and minuses. Research suggests that it can be effective for treating a variety of conditions including anxiety and personality disorders and is at least as effective as other psychotherapy approaches.

Existential Psychotherapy

**Existential psychotherapy** is a style of therapy that places emphasis on the human condition as a whole. Existential psychotherapy uses a positive approach that applauds human capacities and aspirations while simultaneously acknowledging human limitations. Existential psychotherapy shares many similarities with humanistic psychology, experiential psychotherapy, depth psychotherapy, and relational psychotherapy.

## TIMELINE OF EXISTENTIAL THERAPY

Existential therapy developed out of the philosophies of Friedrich Nietzsche and Soren Kierkegaard. As one of the first existential philosophers, Kierkegaard theorized that human discontent could only be overcome through internal wisdom. Later, Nietzsche further developed the theory of existentialism using concepts such as the will to power and personal responsibility. In the early 1900s, philosophers such as Martin Heidegger and Jean-Paul Sartre began to explore the role of investigation and interpretation in the healing process. Over the next several decades, other contemporaries started to acknowledge the importance of experiencing in relation to

understanding as a method to achieving psychological wellness and balance.

Otto Rank was among the first existential therapists to actively pursue the discipline, and by the middle of the 20th century, psychologists Paul Tillich and Rollo May brought existential therapy into the mainstream through their writings and teachings, as did Irvin Yalom after them. The popular approach began to influence other theories, including logotherapy, whic developed by Viktor Frankl, and humanistic psychology. At the same time, British philosophers expanded existentialism further with the foundation of The Philadelphia Association, an organization dedicated to helping people manage their mental health issues with experiential therapies. Other institutions that embody the theory of existentialism include the Society for Existential Analysis, founded in 1988, and the International Community of Existential Counselors, created in 2006.

## EXISTENTIAL PSYCHOTHERAPY 'GIVENS'

Existential psychotherapy is based upon the fundamental belief that all people experience intrapsychic conflict due to their interaction with certain conditions inherent in human existence, which are known as givens. The theories recognize at least four primary existential givens:

- Freedom and associated responsibility
- Death
- Isolation
- Meaninglessness

A confrontation with any of the aforementioned conditions, or givens, fills an individual with a type of dread commonly referred to as existential anxiety. This anxiety is thought to reduce a person's physical, psychological, social, and spiritual awareness, which may lead to significant long-term consequences.

For example, the fact that each one of us and each one of our loved ones must die at some unknown time may be a source of deep anxiety to us, and this may tempt us to ignore the reality and necessity of death in human existence. By reducing our awareness of death, however, we may fail to make decisions that can actually safeguard or even enrich our lives. At the other end of the spectrum, people who are overly conscious of the fact that death is inevitable may be driven to a state of neurosis or psychosis.

The key, according to existential psychotherapy, is to strike a balance between being aware of death without being overwhelmed by it. People who maintain a healthy balance in this way are motivated to make decisions that can positively impact their lives, as well as the lives of their loved ones. Though these people may not know how their decisions will actually turn out, they do appreciate the need to take action while they can. In essence, the reality of death encourages us to make the most of opportunities and to treasure the things we have.

Like death, the threat of isolation, the perceived meaninglessness of life, and the weighty responsibility of making life-altering decisions may each be a source of acute existential anxiety. According to the theories of existential therapy, the manner in which a person processes these internal conflicts, and the decisions they make as a result, will ultimately determine that person's present and future circumstances.

## ACCEPTING FEARS AND OVERCOMING THEM

Existential psychotherapy encourages people to not only address the emotional issues they face through full engagement but to also take responsibility for the decisions that contributed to the development of those issues. People who participate in this form of therapy are guided to accept their fears and given the skills necessary to overcome these fears through action. By gaining control of the direction of their life, the person in therapy is able to work to design the course of their choosing. Through this work, people often come to feel both a sense of liberation and the ability to let go of the despair associated with insignificance and meaningless. Thus, existential psychotherapy involves teaching people in therapy to grow and embrace their own lives and exist in them with wonder and curiosity. Developing the ability to view life with wonder can help people be able to view the life experience as a journey rather than a trial and can also help eradicate the fear associated with death.

## EXISTENTIAL THERAPISTS' PROCESS

Therapists who practice existential psychotherapy do not focus on a person's past. Instead, they work with the person in therapy to discover and explore the choices that lie before them. Through retrospection, the person in therapy and therapist work together to understand the implications of past choices and the beliefs that led those to take place, only as a means to shift to the goal of creating a keener insight into the self. In existential therapy, the emphasis is not to dwell on the past, but to use the past as a tool to promote freedom and newfound assertiveness. By coming to the realization that they are neither unique nor destined for a specific purpose, the person in therapy is able to release the obligatory chains that may have been preventing them from existing in fullness from moment to

moment. When that happens, they then achieve the ability to become truly free.

## HOW CAN EXISTENTIAL PSYCHOTHERAPY HELP?

People in therapy who are willing to explore the reasons for their intrapsychic conflicts and the decisions that led to their current circumstances can benefit greatly from existential psychotherapy. There are many behavioral and mental health issues that may be successfully treated with this therapeutic approach, including depression, anxiety, substance dependency, and posttraumatic stress resulting from exposure to military combat, rape, childhood sexual abuse, interpersonal violence, or other life-threatening experiences.

Individuals who respond to treatment tend to find meaning and purpose in their lives and often experience heightened self-awareness, self-understanding, self-respect, and self-motivation. The realization that they are primarily responsible for their own recovery often increases the likelihood that people in treatment will see beyond the limits of a therapy session and view recovery as a therapeutic process.

## COMMON CONCERNS AND LIMITATIONS

Existential psychotherapy, much like other types of therapy, may be misunderstood by people who do not have a thorough grasp of the fundamental principles or scope of the associated theories. It can help to develop awareness of the principles, theories, and givens before and while participating in treatment.

Common misperceptions of existential psychotherapy include the following beliefs:

- **One distinctive, united existential theory, free of internal tension, covers all the basic assumptions of existential psychology.** In fact, there are at least five categories of the approach, and most scholars view this as a strength of the approach, as it leads to consistent examination of the basic assumptions of the approach and allows for greater adaptability.
- **There is no difference between existential psychology and existential philosophy.** Though there are points of agreement between existential philosophy and existental psychology, there are also points of difference, and the variation in perspectives of the leading pioneers and scholars of the two fields help contribute to the development of each approach.
- **Existential psychology takes an antireligious or anti-spiritual approach, for example, denying the existence of God.** Though existential psychology is not innately religious and does discourage people from following one person or religion without question, it is also not anti-relgious, and many of the leading scholars and pioneers were Christian theologists.
- **Existential and humanistic theories are the same thing.** Though there is agreement between the two theories, they are not identical. However, disagreements between these two schools of thought tend to be more degrees of emphasis and less complete divergences.
- **Existential psychotherapy takes a negative, dark, or pessimistic view of life.** Because writings on existential psychology can be read as pessimistic, due to their view that suffering can be embraced as part of the human existence.

This is not an encouragement of suffering, though, only recognition of the fact that it is an inescapable part of being human. What existential therapy *does* do is encourage people to embrace the reality of suffering in order to work through and learn from it.

- **The approach is fundamentally an intellectual one and, as such, is only beneficial to people of high intellect, who are not experiencing chronic behavioral or mental health conditions.** People of any intelligence level are capable of the awareness of their own humanity and able to make meaning of their emotions and anxieties. It is not necessary for a person to be a philosopher or scholar to benefit from the prinicples of existential therapy, and many people who are actively struggling with mental health issues can also be helped by the approach.

Because existential psychotherapy targets the underlying factors of perceived behavioral and mental health concerns, an existential approach may not directly address the primary issue a person in treatment is experiencing. Because of this, existential therapy, which is quite adaptable, is often used along with other approaches to treatment. Combining approaches can help maximize the effectiveness of both and promote greater recovery. Additionally, the in-depth, penetrative approach used in existential psychotherapy may not appeal to people who do not wish to explore their intrapsychic processes, or who are solely interested in finding a quick fix for their mental health challenges.

## Acceptance And Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) encourages people to embrace their thoughts and feelings rather than fighting or feeling guilty for them.

It may seem confusing at first, but ACT paired with **mindfulness-based therapy** offers clinically effective treatment. After all:

*Running away from any problem only increases the distance from the solution. The easiest way to escape from the problem is to solve it.*

Medical conditions such as anxiety, depression, OCD, addictions, and substance abuse can all benefit from ACT and Mindfulness-Based Cognitive Therapy (MBCT).

ACT develops psychological flexibility and is a form of behavioral therapy that combines mindfulness skills with the practice of self-acceptance. When aiming to be more accepting of your thoughts and feelings, commitment plays a key role. In the case of ACT, you commit to facing the problem head-on rather than avoiding your stresses. Imagine committing to actions that help you facilitate your experience and embrace any challenge.

As you will see later in this piece, ACT is effective for a wide range of psychological disorders, and it is also effective as a life-affirming and inspirational perspective of self-determination.

*"a unique empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility."*

The ACBS views ACT as a therapy based on the concept that suffering is a natural and inevitable condition for humans. We have

an instinct to control our experiences, but this instinct does not always serve us.

The founder of ACT has also offered a definition of ACT in terms familiar to the psychology field:

*"a psychological intervention based on modern behavioral psychology, including* ***Relational Frame Theory****, that applies mindfulness and acceptance processes, and commitment and behavior change processes, to the creation of psychological flexibility" (Hayes, "The Six Core Processes of ACT").*

To put it in less clinical terms, Dr. Russell Harris (2011) has defined ACT as "a mindfulness-based behavioral therapy that challenges the ground rules of most Western psychology." Its unique goal is to help patients create a rich and meaningful life and develop mindfulness skills alongside the existence of pain and suffering.

## Core Processes

Six core processes of ACT guide patients through therapy and provide a framework for developing psychological flexibility (Harris, 2011). These six core processes of ACT include the following:

- Acceptance;
- Cognitive Defusion;
- Being Present;
- Self as Context;
- Values;
- Committed Action.

*Acceptance* is an alternative to our instinct to avoid thinking about negative—or potentially negative—experiences. It is the active choice to allow unpleasant experiences to exist, without trying to deny or change them.

*Acceptance is not a goal of ACT, but a method of encouraging action that will lead to positive results.*

*Cognitive Defusion* refers to the techniques intended to change how an individual reacts to their thoughts and feelings. Acceptance and Commitment Therapy does not intend to limit our exposure to negative experiences, but rather to face them and come out the other side with a decreased fixation on these experiences.

*Being Present* can be understood as the practice of being aware of the present moment, without judgment the experience. In other words, it involves experiencing what is happening without trying to predict or change the experience.

*Self as Context* is the idea that an individual is not simply the sum of their experiences, thoughts, or emotions. The "self as context" process offers the alternative concept that there is a self outside of the current experience.

*We are not only what happens to us. We are the ones experiencing what happens to us.*

**Values** in this context are the qualities we choose to work towards in any given moment. We all hold values, consciously or unconsciously, that direct our steps. In ACT, we use tools that help us live our lives in accordance with the values that we hold dear.

Finally, ACT aims to help patients *commit to actions* that will assist in their long-term goals and live a life consistent with their values.

Positive behavior changes cannot occur without awareness of how a given behavior affects us.

ACT is not all that different from other behavioral-based therapies; it just emphasizes acceptance instead of avoidance, and in that way, differs from many other forms of therapy. This departure from most mainstream treatment can be traced back to the background of ACT's founder, Stephen C. Hayes.

## The Role of ACT in Psychology and Mindfulness

Acceptance and Commitment Therapy is built on the Relational Frame Theory, a theory based on the idea the human ability to relate is the foundation of language and cognition.

Relating involves noting the dimensions along which relation exists. For example, we may associate an apple with an orange, but our ability of relating allows us to understand that although they have a

similar shape (round) and function (to be eaten), they have different colors and textures.

Humans, unlike most other animals, have an uncanny ability to relate even neutral events, as well as seemingly unrelated words and ideas.

While this is an advantageous ability, it also facilitates negative thoughts and judgment about ourselves. If we can relate the word “cookie” to the experience of eating a cookie, then we can also relate the word “worthless” to feeling that we are worthless.

Our ability to form relational networks (e.g., I relate the words “orange”, “apple”, and “pear” to the concept of “fruit”) can be a destructive ability when anxiety and depression impact us.

For example, we might relate “worthless” to an ability to perform my job and, by extension, relate the word “worthless” to my life. ACT is built on **Relational Frame Theory**.

We often form relational networks that are not complimentary or life-giving, but we can also change those relations when we apply mindfulness to accept our feelings and change how we react and relate to them, instead of trying to avoid them.

## 1. Triggers, Behaviors, and Payoffs

This worksheet is a fillable matrix on page 6 with one column for writing down triggers (situations, thoughts, or feeling that immediately precede a certain behavior), behaviors (what you actually do), and payoffs (the immediate outcomes of the behavior that encourage the behavior to continue).

This worksheet can help you or your clients identify self-defeating behaviors with the motivation behind them, which can be a first step to recognizing and modifying problematic behavior.

### 2. Bull's Eye: Clarifying Your Values

Another worksheet presents the Values Bull's Eye, or a set of concentric circles that are separated into four quadrants: work/education, leisure, personal growth/health, and relationships.

The exercise involves placing an "X" on the circle that most closely represents how you feel in the present moment.

The closer to the middle the X is, the more you feel you are behaving like the person you want to be. The further out the X is, the less you feel like the person you want to be.

### 3. The 'Triflex' Psychological Flexibility Assessment Tool

The final pages in the PDF from ACT Mindfully help you estimate your psychological flexibility based on three factors:

1. Ability to open up
2. Ability to be present
3. Ability to do what matters

Here you will find a visual representation of psychological flexibility, an explanation of each of these three factors, and a method of estimating your abilities in these areas at this moment.

### 4. "The Happiness Trap" Worksheets

### The Cost of Avoidance Worksheet

This worksheet present four sentences for you to complete:

1. The thoughts I'd most like to get rid of are:
2. The feelings I'd most like to get rid of are:
3. The sensations I'd most like to get rid of are:
4. The memories I'd most like to get rid of are:

Next, you are asked to write a list of everything you have done to try to avoid or get rid of these thoughts, feelings, sensations, and memories. Distracting yourself from these, avoiding activities, or using substances to self-medicate are a few examples of avoidance techniques.

Then you are asked to consider these questions for each item:

1. Did this action get rid of my painful thoughts and feelings in the long term?
2. Did it bring me closer to a rich, full, and meaningful life?
3. If the answer to question 2 is "no," then what did this action cost me in terms of time, energy, money, health, relationships, and vitality?

This worksheet can help you become aware of your own avoidance strategies, and whether they are producing the results you want.

**Informal Mindfulness Exercises**

This page introduces two simple mindfulness exercises for any typical day:

1. *Mindfulness in Your Morning Routine*: This exercise encourages you to notice the sensations while getting ready in the morning, such as the taste of your toothpaste, the smell of

your face wash, or the feel of hot water on your body in the shower.

2. *Mindfulness of Domestic Chores*: This exercise is one you can practice by simply being aware of the sensations you experience as you sweep the floors, do a load of laundry, or make dinner. Since you "always" have to do the dishes, why not take the time to do it mindfully? It's good for your brain.

This worksheet allows space for you to imagine some informal mindfulness exercises to add to your day, such as while waiting in traffic or while walking from your car to your door. Maybe it's as little as "no-phone" time while you grocery shop or wait in line.

**Values Assessment Rating Form**

The Values Assessment Rating Form provides a matrix with 10 life domains (e.g., couples/intimate relationships, parenting, employment, etc.) and 4 columns to fill out:

- Valued direction (a brief summary of your goal for each domain)
- Importance of this value in your life
- Success in living this value
- Rank in order of importance you place on working on this domain right now

The Values Assessment Rating Form can help you identify where you are falling short of your goals and where you are meeting your goals, as well as aiding the prioritization of meeting these goals going forward.

## Goal Setting Worksheet

This worksheet guides the reader through the values that underlie their goals and how to make sure these goals are SMART goals. SMART is an acronym for goals that are Specific, Meaningful, Adaptive, Realistic, and Time-bound.

This activity will help you understand how to set goals that you can meet, rather than lofty ideas that are not backed by concrete actions.

## What To Do in a Crisis

This informational page offers a practical and useful response for when you face a crisis.

This response is called STOP:

- Slow your breathing: enter into a quick and simple mindfulness practice.
- Take note: noticing what you are experiencing in the present moment.
- Open up: allow yourself to feel without judgment or avoidance.
- Pursue your values: decide what the best course of action is based on your most important values.

Here is a list of things to consider during this exercise:

1. Consider if you need assistance or support, and who could provide you with the assistance or support you need.
2. Think about whether you have experienced anything similar before, and how you responded to it then.

3. Consider ways to improve the situation, even in the smallest way, whether it's in the next few minutes or the next few days.
4. Be willing to practice acceptance if you cannot improve your situation, and commit to spending your time and energy in a constructive way.
5. Ask yourself what the best way is to deal with this situation or, as the metaphor goes, how to play the game with the cards you have been dealt.
6. Remember to practice self-compassion; if you need inspiration, imagine a friend or loved one was going through your experience right now, and tell yourself whatever you imagine telling them.

## 5. Psychological Inflexibility

For therapists and other mental health professionals from The HappinessTrap aligns with ACT principles as well. It provides questions for you to assess your clients for their psychological inflexibility.

Psychological inflexibility is the extent to which anyone has trouble practicing the six core processes. The questions map to the opposite of the six core processes as follows:

- The dominance of the conceptualized past or future; limited self-knowledge (vs. acceptance)
- Fusion (vs. defusion)
- Experiential avoidance (vs. being present)
- Attachment to the conceptualized self (vs. self as context)
- Lack of values clarity/contact (vs. values)

- Unworkable action (vs. committed action)

This set of questions can be a great tool to help your clients ascertain where to focus their energy. This is a critical step to embracing their experiences and act according to their deepest values.

## Behavioral Therapy Is Used in Psychology

In behavioral therapy, the goal is to reinforce desirable behaviors and eliminate unwanted or maladaptive ones. Behavioral therapy is rooted in the principles of behaviorism, a school of thought focused on the idea that we learn from our environment. The techniques used in this type of treatment are based on the theories of classical conditioning and operant conditioning.

One important thing to note about the various behavioral therapies is that unlike some other types of therapy that are rooted in insight (such as psychoanalytic and humanistic therapies), behavioral therapy is action-based. Behavioral therapists are focused on using the same learning strategies that led to the formation of unwanted behaviors.

Because of this, behavioral therapy tends to be highly focused. The behavior itself is the problem and the goal is to teach clients new behaviors to minimize or eliminate the issue. *Old learning* led to the development of a problem, and so the idea is that *new learning* can fix it.

There are three major areas that also draw on the strategies of behavioral therapy:

- **Cognitive-behavioral therapy** relies on behavioral techniques but adds a cognitive element, focusing on the problematic thoughts that lie behind behaviors.

- **Applied behavior analysis** uses operant conditioning to shape and modify problematic behaviors.
- **Social learning theory** centers on how people learn through observation. Observing others being rewarded or punished for their actions can lead to learning and behavior change.

Edward Thorndike was one of the first to refer to the idea of modifying behavior. Other early pioneers of behavior therapy included psychologists Joseph Wolpe and Hans Eysenck. Behaviorist B.F. Skinner's work had a major influence on the development of behavior therapy and his work introduced many of the concepts and techniques that are still in use today.

Later on, psychologists such as Aaron Beck and Albert Ellis began adding a cognitive element to behavioral strategies to form a treatment approach known as cognitive-behavioral therapy (CBT).

The Foundation of Behavioral Therapy

In order to understand how behavioral therapy works, let's start by exploring the two basic principles that contribute to behavioral therapy: Classical and operant conditioning.

- **Classical conditioning** involves forming associations between stimuli. Previously neutral stimuli are paired with a stimulus that naturally and automatically evokes a response. After repeated pairings, an association is formed and the previously neutral stimulus will come to evoke the response on its own.
- **Operant conditioning** focuses on how reinforcement and punishment can be utilized to either increase or decrease the frequency of a behavior. Behaviors followed by desirable consequences are more likely to occur again in the future,

while those followed by negative consequences become less likely to occur.

## Behavior Therapy Based on Classical Conditioning

Classical conditioning is one way to alter behavior, and a number of techniques exist that can produce such change. Originally known as behavior modification, this type of therapy is often referred to today as applied behavior analysis. There are several different techniques and strategies used in this approach to therapy.

## Flooding

This process involves exposing people to fear-invoking objects or situations intensely and rapidly. It is often used to treat phobias. During the process, the individual is prevented from escaping or avoiding the situation.

For example, flooding might be used to help a person who is suffering from an intense fear of dogs. At first, the client might be exposed to a small, friendly dog for an extended period of time during which they cannot leave. After repeated exposures to the dog during which nothing bad happens, the fear response begins to fade.

## Systematic Desensitization

In this technique, a client makes a list of fears and then learns to relax while concentrating on these fears. The use of this process began with psychologist John B. Watson and his famous Little Albert experiment in which he conditioned a young child to fear a white rat. Later, Mary Cover Jones replicated Watson's results and utilized counterconditioning techniques to desensitize and eliminate the fear response.

Systematic desensitization is often used to treat phobias and other anxiety disorders. The process follows three basic steps.

1. First, the therapist teaches the client relaxation techniques.
2. Next, the individual creates a ranked list of fear-invoking situations.
3. Starting with the least fear-inducing item and working their way up to the most fear-inducing item, the client confronts these fears under the guidance of the therapist while maintaining a relaxed state.

For example, an individual with a fear of the dark might start by looking at an image of a dark room, before moving on to thinking about being in a dark room, and then actually confronting his fear by sitting in a dark room. By pairing the old fear-producing stimulus with the newly learned relaxation behavior, the phobic response can be reduced or even eliminated.

## Aversion Therapy

This process involves pairing an undesirable behavior with an aversive stimulus in the hope that the unwanted behavior will eventually be reduced. For example, someone suffering from alcoholism might take disulfiram, a drug which causes severe symptoms (such as headaches, nausea, anxiety, and vomiting) when combined with alcohol.

## How Aversion Therapy Works to Fix Unwanted Behaviors

Behavior Therapy Based on Operant Conditioning

Many behavior techniques rely on the principles of operant conditioning, which means that they use reinforcement, punishment, shaping, modeling and related techniques to alter behavior. These

methods have the benefit of being highly focused, which means that they can produce fast and effective results.

## Token Economies

This type of behavioral strategy relies on reinforcement to modify behavior. Clients are allowed to earn tokens that can be exchanged for special privileges or desired items. Parents and teachers often use token economies to reinforce good behavior.

Kids earn tokens for engaging in preferred behaviors and may lose tokens for displaying undesirable behaviors. These tokens can then be traded for rewards such as candy, toys, or extra time playing with a favorite toy.

## Contingency Management

This approach uses a formal written contract between a client and a therapist (or parent or teacher) that outlines behavior-change goals, reinforcements, rewards, and penalties. Contingency contracts can be very effective in producing behavior changes since the rules are spelled out clearly, preventing both parties from backing down on their promises.

## Modeling

This technique involves learning through observation and modeling the behavior of others. The process is based on Albert Bandura's social learning theory, which emphasizes the social components of the learning process.

Rather than relying simply on reinforcement or punishment, modeling allows individuals to learn new skills or acceptable behaviors by watching someone else perform those desired skills. In some cases, the therapist might model the desired behavior. In

other instances, watching peers engage in sought-after behaviors can also be helpful.

### Extinction

Another way to produce behavior change is to stop reinforcing a behavior in order to eliminate the response. Time-outs are a perfect example of the extinction process.

During a time-out, a person is removed from a situation that provides reinforcement. For example, a child who starts yelling or striking other children would be removed from the group and required to sit quietly in a place where there are no opportunities for attention and reinforcement. By taking away the attention that the child found rewarding, the unwanted behavior is eventually extinguished.

## Rational Emotive Behavior Therapy (REBT)

Rational emotive behavior therapy, also known as REBT, is a type of cognitive-behavioral therapy developed by psychologist Albert Ellis. REBT is focused on helping clients change irrational beliefs.

History of Rational Emotive Behavior Therapy

As a young man, Ellis found himself longing for companionship yet experienced a severe fear of talking to women. In order to tackle his fear, Ellis decided to perform an experiment. For a month, he visited a nearby park and forced himself to talk to 100 different women.

Over time, Ellis found that his fear of speaking to women had diminished considerably. This experience served as a basis for developing his approach to therapy, combining behavioral strategies with assessing underlying thoughts and emotions.

Ellis had trained as a clinical psychologist. As he treated patients, he became increasingly dissatisfied with the results offered by the traditional psychoanalytic approach to therapy. While his patients were able to become aware of their underlying problems, their behavior did not necessarily change. Simply becoming conscious of the problem was not enough, he concluded.

By the 1950s, Ellis had started experimenting with other types of psychotherapy. He was heavily influenced by philosophers and psychologists including Karen Horney and Alfred Adler, as well as the work of behavioral therapists. Ellis's goal was to develop what he viewed as an action-oriented approach to psychotherapy designed to produce results by helping clients manage emotions, cognitions, and behaviors.

"People are not disturbed by things but rather by their view of things," Ellis said. The fundamental assertion of rational emotive behavior therapy (REBT) is that the way people feel is largely influenced by how they think.[1]

When people hold irrational beliefs about themselves or the world, problems can result. The goal of REBT is to help people alter illogical beliefs and negative thinking patterns in order to overcome psychological problems and mental distress.[2]

Rational emotive behavior therapy was one of the very first types of cognitive therapies. Ellis first began developing REBT during the early 1950s and initially called his approach "rational therapy."[1] In 1959, the technique was renamed "rational emotive therapy," and then became "rational emotive behavior therapy" in 1992. Ellis continued to work on REBT until his death in 2007.

The ABC Model

Ellis suggested that people mistakenly blame external events for unhappiness. He argued, however, that it is our *interpretation* of these events that truly lies at the heart of our psychological distress. To explain this process, Ellis developed what he referred to as the ABC Model.

- **A — Activating Event:** Something happens in the environment around you.
- **B — Beliefs:** You hold a belief about the event or situation.
- **C — Consequence:** You have an emotional response to your belief.[1]

The events and situations that people encounter throughout life are only one piece of the puzzle. In order to understand the impact of such events, it is also essential to look at the beliefs people hold about these experiences as well as the emotions that arise as a result of those beliefs.

The Basic Steps of REBT

In order to better understand how REBT looks, it is important to take a closer look at the therapeutic process itself.

Identify Irrational Thought Patterns and Beliefs

The very first step in the process is to identify the underlying, irrational thoughts, feelings, and beliefs that lead to psychological distress. In many cases, these irrational beliefs are reflected as absolutes, as in "I must," "I should," or "I cannot." According to Ellis, some of the most common irrational beliefs include:

- Feeling excessively upset over other people's mistakes or misconduct

- Believing that you must be 100% competent and successful in everything to be valued and worthwhile
- Believing that you will be happier if you avoid life's difficulties or challenges
- Feeling that you have no control over your own happiness, that your contentment and joy are dependent upon external forces[1]

Holding such unyielding beliefs makes it almost impossible to respond to activating situations in a psychologically healthy way. Possessing such rigid expectations of ourselves and others only leads to disappointment, recrimination, regret, and anxiety.

Challenge Irrational Beliefs

Once these underlying feelings have been identified, the next step is to challenge the mistaken beliefs. In order to do this, the therapist disputes these beliefs using very direct and even confrontational methods.

Ellis suggested that rather than simply being warm and supportive, therapists need to be blunt, honest, and logical in order to push people toward changing their thoughts and behaviors.

Gain Insight and Change Behavior

As you might imagine, REBT can be a daunting process for the client. Facing irrational thought patterns can be difficult, especially because accepting these beliefs as unhealthy is far from easy. Once the client has identified the problematic beliefs, the process of actually changing these thoughts can be even more challenging.

While it is perfectly normal to feel upset when making a mistake, the goal of REBT is to help people respond rationally to such situations. When faced with this type of situation in the future, the emotionally

healthy response would be to realize that it is not realistic to expect success in every endeavor. You made a mistake, but that's okay. Everyone makes mistakes. All you can do is learn from the situation and move on.

While REBT uses cognitive strategies, it focuses on emotions and behaviors as well.[2] In addition to identifying and disputing irrational beliefs, therapists and clients also work together to target the emotional responses that accompany problematic thoughts. Clients are encouraged to change unwanted behaviors using strategies such as meditation, journaling, and guided imagery.

## Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is a type of psychotherapeutic treatment that helps people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behavior and emotions.[1]

Cognitive behavioral therapy focuses on changing the automatic negative thoughts that can contribute to and worsen emotional difficulties, depression, and anxiety. These spontaneous negative thoughts have a detrimental influence on mood.

Through CBT, these thoughts are identified, challenged, and replaced with more objective, realistic thoughts.

CBT is about more than identifying thought patterns; it is focused on using a wide range of strategies to help people overcome these thoughts. Such strategies may include journaling, role-playing, relaxation techniques, and mental distractions.

Types of Cognitive Behavioral Therapy

CBT encompasses a range of techniques and approaches that address thoughts, emotions, and behaviors. These can range from structured psychotherapies to self-help materials. There are a number of specific types of therapeutic approaches that involve CBT:

- **Cognitive therapy** centers on identifying and changing inaccurate or distorted thinking patterns, emotional responses, and behaviors.[3]
- **Dialectical behavior therapy (DBT)** addresses thoughts and behaviors while incorporating strategies such as emotional regulation and mindfulness.
- **Multimodal therapy** suggests that psychological issues must be treated by addressing seven different but interconnected modalities, which are behavior, affect, sensation, imagery, cognition, interpersonal factors, and drug/biological considerations.[4]
- **Rational emotive behavior therapy (REBT)** involves identifying irrational beliefs, actively challenging these beliefs, and finally learning to recognize and change these thought patterns.

While each type of cognitive behavioral therapy takes a different approach, all work to address the underlying thought patterns that contribute to psychological distress.

Uses

Cognitive-behavior therapy can be effectively used as a short-term treatment centered on helping people with a very specific problem and teaching them to focus on present thoughts and beliefs.[1] CBT is used to treat a wide range of conditions including:

- Addictions
- Anger issues
- Anxiety[2]
- Bipolar disorder
- Depression
- Eating disorders
- Panic attacks
- Personality disorders
- Phobias[5]
- Problems with stress

Cognitive behavioral therapy is highly goal-oriented and focused, with the therapist taking a very active role. People work with their therapist toward mutually established goals. The process is explained in detail and people are often given homework to complete between sessions.

Impact

The underlying concept behind CBT is that thoughts and feelings play a fundamental role in behavior.[1] For example, a person who spends a lot of time thinking about plane crashes, runway accidents, and other air disasters may avoid air travel as a result.

The goal of cognitive behavior therapy is to teach people that while they cannot control every aspect of the world around them, they can take control of how they interpret and deal with things in their environment.

Cognitive behavior therapy has become increasingly popular in recent years with both mental health consumers and treatment professionals. Some reasons for this include:

- By becoming aware of the negative and often unrealistic thoughts that dampen their feelings and moods, people are able to start engaging in healthier thinking patterns.[1]
- CBT can be an effective short-term treatment option.
- It can help people with certain types of emotional distress that don't require psychotropic medication.
- It is empirically supported and has been shown to effectively help patients overcome a wide variety of maladaptive behaviors.[1]
- It is often more affordable than some other types of therapy.

One of the greatest benefits of cognitive behavioral therapy is that it helps clients develop coping skills that can be useful both now and in the future.[1]

CBT Strategies

People often experience thoughts or feelings that reinforce or compound faulty beliefs. Such beliefs can result in problematic behaviors that can affect numerous life areas, including family, romantic relationships, work, and academics.

## Identify Negative Thoughts

It is important to learn how thoughts, feelings, and situations can contribute to maladaptive behaviors.[6] The process can be difficult, especially for people who struggle with introspection, but it can

ultimately lead to self-discovery and insights that are an essential part of the treatment process.

**Practice New Skills**

It is important to start practicing new skills that can then be put in to use in real-world situations. For example, a person with a substance use disorder might start practicing new coping skills and rehearsing ways to avoid or deal with social situations that could potentially trigger a relapse.

**Set Goals**

Goal setting can an important step in recovery from mental illness and helping you make changes to improve your health and life. During CBT, a therapist can help with goal-setting skills by teaching you how to identify your goal, distinguish between short- and long-term goals, set SMART (specific, measurable, attainable, relevant, time-based) goals, and focus on the process as much as the end outcome.

**Problem Solve**

Learning problem solving skills can help you identify and solve problems that arise from life stressors, both big and small, and reduce the negative impact of psychological and physical illness. Problem solving in CBT often involves five steps: identifying a problem, generating a list of possible solutions, evaluating the strengths and weaknesses of each possible solution, choosing a solution to implement, and implementing the solution.[7]

**Self Monitor**

Also known as diary work, self-monitoring is an important part of CBT that involves tracking behaviors, symptoms, or experiences

over time and sharing them with your therapist. Self-monitoring can help provide your therapist with the information needed to provide the best treatment. For example, for eating disorders, self-monitoring may involve keeping track of eating habits as well as any thoughts or feelings that went along with consuming that meal or snack.[8]

## Progress Gradually

In most cases, CBT is a gradual process that helps a person take incremental steps towards a behavior change. For example, someone with social anxiety might start by simply imagining anxiety-provoking social situations. Next, they might start practicing conversations with friends, family, and acquaintances.

By progressively working toward a larger goal, the process seems less daunting and the goals easier to achieve.

## How Behavioral Therapy Is Used in Psychology

## Potential Pitfalls

There are several challenges that people may run into during the course of cognitive behavioral therapy.

Change Can Be Difficult

Initially, some patients suggest that while they recognize that certain thoughts are not rational or healthy, simply becoming aware of these thoughts does not make it easy to alter them.

## CBT Is Very Structured

Cognitive behavioral therapy doesn't tend to focus on underlying unconscious resistances to change as much as other approaches such as psychoanalytic psychotherapy.[9] It is often best-suited for

clients who are more comfortable with a structured and focused approach in which the therapist often takes an instructional role.

### People Must Be Willing to Change

For cognitive behavioral therapy to be effective, the individual must be ready and willing to spend time and effort analyzing their thoughts and feelings. Such self-analysis and homework can be difficult, but it is a great way to learn more about how internal states impact outward behavior.

### What to Expect During Your First Therapy Session

### History

CBT emerged during the 1960s and originated in the work of psychiatrist Aaron Beck, who noted that certain types of thinking contributed to emotional problems. Beck labeled these "automatic negative thoughts" and developed the process of cognitive therapy.

Where earlier behavior therapies had focused almost exclusively on associations, reinforcements, and punishments to modify behavior, the cognitive approach addressed how thoughts and feelings affect behaviors.

Since then, CBT has emerged as an effective first-line treatment for a wide range of disorders and conditions.

## Mindfulness-Based Cognitive Therapy (MBCT)

### Mindfulness-based cognitive therapy (MBCT)

combines cognitive behavioral techniques with mindfulness strategies in order to help individuals better understand and manage

their thoughts and emotions in order to achieve relief from feelings of distress.

Though originally developed to address recurrent depression, MBCT may be beneficial to people seeking treatment for a wide range of mental health concerns.

## DEVELOPMENT OF MBCT

MBCT, which was developed by Zindel Segal, Mark Williams, and John Teasdale, is primarily derived from the earlier work of Teasdale, Jon Kabat-Zinn, and Phillip Barnard.

The approach, which is still relatively new—the first clinical trial was published in 2000—incorporates principles from Kabat-Zinn's mindfulness-based stress reduction modality, an 8-week program designed to help people cope with the mental and physical effects of health concerns, and Bernard and Teasdale's ICS (interactive cognitive subsystems) model. ICS is based on the premise that the human mind possesses different modes for receiving and processing data, the two primary modes of which are the “being” mode and the “doing” mode. The model also suggests mental health may be dependent on a person's ability to detach from one mode and move between other modes, based on what is present in the environment. The MBCT program emphasizes the “being” mode, as this mode is believed to promote lasting emotional change, specifically for individuals experiencing recurrent depressive episodes.

## HOW DOES MBCT WORK?

In this therapy approach, people can learn how to use cognitive methods and mindfulness meditation to interrupt the automatic processes often triggering depression. Low mood, negative

thoughts, and certain body sensations such as weariness and sluggishness often occur together during an episode of depression. Even after the episode passes, connections may still exist between the different symptoms, and it is possible for a small negative stimulus to trigger a large downward spiral: Researchers have found when people with a history of depression experience a low mood, they may also experience negative memories and thoughts from the past, which may, in turn, lead to worry about the future and physical sensations such as fatigue.

MBCT helps participants learn how to recognize their sense of being and see themselves as separate from their thoughts and moods. This disconnect can allow people to become liberated from thought patterns in which the same negative messages may be replayed over and over. After developing an awareness of the separation between thoughts, emotions, and the self, people in treatment may find that while the self and the emotions may exist simultaneously, they do not have to exist within the same dimension. This insight can contribute to healing by helping individuals learn to interject positive thoughts into negative moods in order to disarm those negative moods.

In general, MBCT attempts to give participants the necessary tools to combat depressive symptoms as they arise. People who learn these skills may then be able to revert to these methods in times of distress or when faced with potentially overwhelming situations.

## TECHNIQUES USED IN MBCT

This therapy is delivered as a weekly group treatment program over the course of eight weeks. Each weekly session lasts for two hours, but completing a 45-minute homework assignment six days a week is also required. For homework, participants listen to audio

recordings and practice mindfulness meditation. People in treatment are also introduced to a technique called the three-minute breathing space. This technique encourages participants to incorporate formal practice into their day-to-day life.

Though there is currently no consensus as to how mindfulness should be defined, the basic concept refers to the practice of developing, in a non-judgmental manner, a deeper awareness of what is happening within one's mind and body from moment to moment. Certain meditation techniques—breathing meditations, sitting meditations, body scan meditations, walking meditations, and yoga—may help to improve a person's mindfulness. In MBCT, individuals in treatment are also taught cognitive concepts such as the association between thoughts and feelings, and they also often have the opportunity to develop a deeper understanding of depression.

## ISSUES TREATED WITH MBCT

Mindfulness is believed to promote good health, and many studies have associated mindfulness with decreases in depression and anxiety. Thus, many mental health professionals have incorporated mindfulness-promoting activities into therapy sessions, and these activities have been shown to help reduce symptoms of depression, decrease stress, and improve emotional control, regardless of the specific issues being addressed.

MBCT in particular may be used as a primary treatment modality or in conjunction with other forms of therapy. Individuals experiencing certain medical concerns may also obtain benefit from MBCT: In a 2013 study of 33 women with fibromyalgia, researchers found that those who were treated with MBCT demonstrated a significantly reduced impact of fibromyalgia, a significant decrease in depressive

symptoms, and a slight decrease in the intensity of bodily pain when compared to those who did not receive MBCT. Researchers have also shown individuals with cancer, diabetes, chronic pain, and epilepsy who incorporate MBCT into treatment plans may see improvement in well-being.

Over the past 15 years, the results of numerous randomized controlled trials have demonstrated that MBCT can be a powerful intervention for people who have experienced clinical depression three or more times. Evidence indicates MBCT may reduce the rate of relapse for individuals with recurrent depression by 50%. MBCT has also been applied to mood and anxiety concerns other than depression, with reported success. A 2014 review of the usefulness of MBCT as a treatment modality for several health conditions found the approach may be effective when addressing issues such as depressive relapse, current depression, residual depression, bipolar, anxiety, food and eating issues, and psychosis, among others.

## TRAINING AND CERTIFICATION

Certification in MBCT is provided by a number of approved institutions around the world, including the UCSD Mindfulness-Based Professional Training Institute (United States), the Oxford Mindfulness Centre (England), the University of Geneva (Switzerland), The Centre for Mindfulness Studies (Canada), and Bangor University (Wales). Therapists who are interested in gaining certification as a teacher of MBCT are required to fulfill two training phases: teacher qualification and teacher certification.

The teacher qualification phase provides applicants with the necessary foundation for teaching MBCT. It consists of six steps:

- Satisfy the prerequisites for a five-day MBCT teacher training retreat
- Attend and participate in the retreat or acquire equivalent training
- Successfully complete either the MindfulNoggin Online MBCT course or the Participant Observer in Live MBCT course
- Apply for teacher-in-training status after successful completion of the program
- Receive a minimum of 20 hours of mentorship while teaching at least two MBCT courses, where each course lasts for eight weeks
- Submit application for teacher qualification

Once teacher qualification status has been achieved, applicants may present themselves as a “qualified teacher of MBCT” and begin phase two of the training process if they wish to pursue certification. Teacher certification involves the following five steps:

- Obtain teacher qualification
- Teach at least three additional eight-week MBCT courses after receiving teacher qualification
- Attend and complete the Advanced Teacher Training Intensive (ATTI)
- Receive a minimum of 10 hours of mentorship while teaching an MBCT course
- Submit application for teacher certification

## LIMITATIONS AND CONCERNS

The effectiveness of mindfulness based cognitive therapy is supported by considerable empirical evidence and has. according to research, generally produced positive results for people in treatment. However, because it is a relatively new treatment modality, the long-term benefits of this approach may not yet be fully determinable. A growing body of empirical evidence supports the approach, but further research may provide greater support for its effectiveness when treating bipolar, eating issues, psychosis, and other conditions.

Several critics have highlighted methodological shortcomings in some MBCT studies such as small sample size, a lack of control groups, and a lack of randomization, all of which have potential to affect the results obtained. More rigorous studies are needed to evaluate whether MBCT is more effective than other, more widely practiced forms of therapy, such as cognitive behavioral therapy.

## Play therapy

Play therapy is a form of therapy primarily geared toward children. In this form of therapy, a therapist encourages a child to explore life events that may have an effect on current circumstances, in a manner and pace of the child's choosing, primarily through play but also through language.

Play therapy, can help individuals communicate, explore repressed thoughts and emotions, address unresolved trauma, and experience personal growth and is widely viewed as an important, effective, and developmentally appropriate mental health treatment.

### HISTORY AND DEVELOPMENT OF PLAY THERAPY

Though some of the earliest theories and methods mentioned below are no longer practiced and may not be acceptable based on current research and ethical standards, they did play a part in advancing play therapy to the extent that it is now regarded as an established therapeutic approach. Some key individuals in the development of this therapy and their contributions to the field include:

- **Hermine Hug-Hellmuth**, who is widely regarded as the world's first psychoanalyst to specialize in treating children and the first person to use play as a form of therapy. In 1921, she introduced a formal play therapy process by providing the children in her care with the necessary materials to express themselves and advocated the use of play to analyze children.
- **Melanie Klein**, who used play as an analytic tool as well as a means to attract the children she worked with to therapy. Klein believed play provided insight into a child's unconscious.
- **David Levy**, who developed a therapeutic approach called "release therapy" in 1938. This was a structured approach that encouraged a traumatized child to engage in free play. The therapist then gradually introduced materials related to the traumatic event, allowing the child to re-experience the stressful event and release any unresolved emotions or actions.
- **Joseph Soloman**, who used an approach called "active play" to assist children who displayed impulsivity and a tendency to act out. The approach was based on Soloman's belief that expressing emotions such as fear and anger in play would result in more socially acceptable behavior.

- **Anna Freud**, who presented theoretical arguments for the use of play as a means to build a positive relationship between the child and therapist, thus allowing the therapist better access to a child's inner thoughts and emotions.
- **Carl Rogers**, who developed person-centered therapy during the 1940s and 1950s. This type of therapy emphasizes the importance of genuineness, trust, and acceptance in the therapeutic relationship.
- **Virginia Axline**, who developed nondirective play therapy by modifying Rogers' approach into a play therapy technique that was more appropriate for children.
- **Roger Phillips**, who posited the idea to combine cognitive therapy

  and play therapy in the early 1980s. Cognitive behavioral play therapy has been used to treat children as young as two years old.

## THE NEUROSCIENCE BEHIND THE IMPORTANCE OF PLAY

Though play is often regarded simply as a way for individuals, particularly children, to relax, scientific research has proven that play is a crucial factor in healthy child development. Studies show that newborn babies possess billions of brain cells; however, these young cells lack the complex neural interconnectivity that is characteristic of a mature, fully-functional human brain. Neuroscience has revealed that the majority of the brain's growth takes place within the first five years of a child's life, and the act of play contributes significantly toward the development of interconnections between neurons. These neural links play a major

role in key areas of the child's life, such as learning, social development, emotional development, and memory.

Play is considered to be especially important for the healthy development of children who have experienced stressful events or past trauma. While the effects of trauma tend to reside in the nonverbal areas of the brain—the hippocampus, amygdale thalamus, and brain stem—a person's capacity to communicate and process adverse issues resides in the brain's frontal lobes. As a result, children affected by trauma may find it difficult to let other people know that they need help. The physical and role-playing activities associated with play therapy have proven instrumental in helping to move traumatic memories and sensations from the nonverbal brain areas to the frontal lobes.

## HOW DOES PLAY THERAPY WORK?

When children are experiencing adverse personal issues they will often act out or engage in inappropriate behavior. Parents may be eager to help but may find it difficult or impossible to offer effective aid if a child is unable or unwilling to discuss the problem. Play therapy is thought to be one of the most beneficial means of helping children who are experiencing emotional or behavioral challenges. Though the approach may benefit people of all ages, it is specially designed to treat children under 12. A typical session may last for 30-45 minutes and may be conducted with one child only or in groups.

During treatment, the therapist creates a comfortable, safe environment in which the child is allowed to play with as few limits as possible. This counseling space is often referred to as a playroom, and it comes equipped with a selection of specifically chosen toys that are meant to encourage the child to express his or

her feelings and develop healthier behaviors. The child's interactions with these toys essentially serve as the child's symbolic words. This allows the therapist to learn about specific thoughts and emotions that a child may find difficult or impossible to express verbally.

Toys used in therapy may include a sandbox with associated miniature figurines, art materials, Legos or other construction toys, costumes or other clothing, stuffed animals, dolls, a dollhouse with miniature furniture, puppets, indoor sports equipment, and other indoor games. The therapist may also incorporate the use of tools and techniques such as clay, therapeutic storytelling, music, dance and movement, drama/role play, and creative visualization.

At first children in therapy are generally allowed to play as they wish. As treatment progresses, the therapist may begin to introduce specific items or play activities which are related to the issues the child is facing. Play therapy may benefit the child in a variety of ways such as encouraging creativity, promoting healing from traumatic events, facilitating the expression of emotions, encouraging the development of positive decision-making skills, introducing new ways of thinking and behaving, learning problem-solving skills, developing better social skills, and facilitating the communication of personal problems or concerns.

Play therapy may be nondirective or directive. Nondirective play therapy is grounded in the idea that if allowed optimal therapeutic conditions and the freedom to play, children in therapy will be able to resolve issues on their own. This approach is viewed as non-intrusive since there is minimal instruction from the therapist regarding how a child should engage in play. Directed play therapy involves much greater input from the therapist and is based on the

belief that faster therapeutic results may be obtained than in nondirective play therapy sessions.

## PLAY THERAPY FOR ADULTS

Play therapy can also be used to treat issues faced by teenagers and adults. By adulthood, most people have lost their ability to playfully explore themselves. Play therapists are trained to help adolescents, adults, and even the elderly relearn the values of play. Playful exploration has been proven to enhance both cognitive and physical behaviors, and there is a significant amount of research from the fields of neurophysiology and molecular biology that supports play therapy as a valid therapeutic technique for those past childhood. A growing number of organizations and experts are dedicated to play research and advocacy, believing that play is important for people of all ages.

Play has been shown to optimize learning, enhance relationships, and improve health and well-being. Adults and children engaged in a therapeutic alliance that focuses on play have an opportunity to choose from a variety of modalities such as movement (body play), sand play, dream play, nature play, social play, pretend (fantasy) play, creative play, storytelling, and vocal play. Play therapy may be used to address a variety of health challenges experienced by adults, especially if incorporated with other treatment modalities. One of the most significant benefits is that play can provide a comfortable and safe environment that may prompt an adult to approach more serious issues.

Play therapy can be used to treat (in children or adults):

- Dementia
- Grief and loss

- Posttraumatic stress
- Obsessions and compulsions
- Attention deficit hyperactivity
- Mood issues
- Anxiety
- Depression
- Developmental issues
- Arrested emotional development

## GUIDELINES FOR EFFECTIVE PLAY THERAPY

Play therapy has proven to be an effective therapeutic approach for people from all age groups, though minors respond particularly well to this type of treatment. Therapists may employ several general guidelines and practices in treatment in order to foster the greatest benefits for people in their care.

When working with a child, a therapist may provide adjunctive therapy for adults who play key roles in the child's life. Throughout therapy, the therapist will typically place emphasis on the promotion of mental health and psychosocial development, explaining treatment plans to the person receiving treatment and a child's legal guardians, if necessary. Therapists may also coordinate treatment with doctors or other health care professionals to ensure that a child's welfare remains the treatment priority. If inappropriately touched by a child in treatment, the therapist may find it best to explain that it is important that each person's body is respected, document the event, then discuss the situation with the child's legal guardians at the earliest opportunity. A therapist may also find it

necessary to make arrangements to prevent the child, or any person they are treating, from feeling abandoned, should there be a break in treatment.

## TRAINING FOR PLAY THERAPISTS

Mental health professionals who seek specialized training and experience in play therapy may earn their credentials from the Association for Play Therapy (APT). The APT is a nationally recognized professional institution which aims to further the play therapy modality and advance the expertise and knowledge of mental health professionals involved in the clinical practice, instruction, and supervision of play therapy. The APT offers two standard credentials: the Registered Play Therapist ™ (RPT) and the Registered Play Therapist-Supervisor ™ (RPT-S).

**Applicants desiring to become a Registered Play Therapist ™ must:**

- Possess an active individual state license which allows him or her to independently provide clinical mental health services.
- Have earned a master's degree or higher in a mental health field, with special emphasis on areas such as child development, psychotherapy, theories of personality, ethics, or child and adolescent psychopathology.
- Have two years of general clinical experience (as required for state licensure) and 2000 hours of general mental health clinical experience.
- Complete 150 hours of play therapy instruction from APT-approved providers or tertiary level academic institutions.

To become a Registered Play Therapist-Supervisor ™, an applicant must also have 500 hours of experience in play therapy, conducted under supervision, plus an additional 50 hours of field-specific supervision.

The Registered Play Therapist ™ (RPT) credential lasts for one year, and it must be renewed annually to maintain active status. To qualify for renewal, the applicant must have a current and active state license to offer clinical mental health services and follow a continuing education cycle by receiving 18 hours of instruction specific to play therapy from a tertiary level academic institution or an APT-approved provider every 36 months.

## Positive Psychotherapy (PPT)

Positive Psychotherapy (PPT) is a relatively new therapeutic approach, influenced by both the humanistic and psychodynamic approaches towards diagnosis and treatment. Its core focus is on moving away from what's 'wrong' or the negative aspects of an individual, and instead move towards what's good and positive.

Seligman, Rashid, and Parks (2006) offer the following definition for PPT concerning depression:

*Positive psychotherapy (PPT) contrasts with* ***standard interventions*** *for depression by increasing positive emotion, engagement, and meaning rather than directly targeting depressive symptoms.*

PPT often uses a range of interdisciplinary approaches of **psychotherapy**, including the use of multicultural stories, ideas, and metaphors to help individuals create a new view of their mental health in positive ways. Therapists using PPT often invite the individual to place themselves in the stories used, so they become

active in their healing process in an empowered way, and in so doing, become the 'therapist' of their own recovery.

While the emphasis is on positivity and positive outcomes, the overall theory of PPT also asserts that three core principles need to be addressed to allow this to happen:

1. *The Principle of Hope*: This principle encourages the individual to focus on the overall positivity of humanity, and negative experiences are to be seen as having a higher purpose with a positive reframing. Any disruptions to a sense of well-being are encouraged to be explored and reframed as signals that there is an imbalance that requires addressing.

2. *The Principle of Balance*: This principle examines how we experience discontent and the coping methods we might use to address this. According to PPT, negative symptoms arise when these coping methods aren't working, and our areas of life are out of balance, with discontent impacting how we think and feel.

1. Peseschkian (1979) ascertained there are four key areas where we will experience imbalance: body/sense, achievement/activities, contact/environment, and fantasy/future. These are the areas PPT focuses on when exploring and addressing the principle of balance.

2. *The Principle of Consultation*: This principle sets out the five stages of therapy that must be worked through to address any issues that arise in the above two principles, to achieve a positive outcome:

1. *Observation* – where the individual provides an account of the issues, challenges, or situations that are upsetting them and those that are making them happy.
2. *Inventory* – where the therapist and individual work together to explore and highlight the correlation between negative feelings/symptoms and the individual's true capabilities.
3. *Situational Support* – where the individual is asked to focus on their positive traits and those of the people around them who significantly offer them support.
4. *Verbalization* – where the individual is encouraged to verbally discuss and talk openly about any negative feelings, challenges, or symptoms.
5. *Development of Goals* – where the individual is invited to turn their focus to the future, setting positive goals, and envisioning the positive feelings they want to cultivate, as well as connecting these with their unique strengths.

Another core component of PPT is the emphasis it places on core capabilities. According to PPT theory, everyone – regardless of gender, age, class, ethnicity, or preconceived ideas of their mental health – has two core capabilities:

1. *The Capability of Perception*: Our ability to draw connections between the different areas of life with more significant reasons behind the meaning of not only our own existence but the existence of everything around us.

2. *The Capability of Love*: Our ability to develop emotionally and develop interpersonal relationships.

Pesechkian (1979) concluded that these two core capabilities are what lay behind our further abilities. PPT seeks to explore an individual's two core capabilities to understand better and, where appropriate, address imbalances to create additional positive outcomes.

Due to its openness around utilizing multicultural stories and ideas, one criticism of PPT is that it does not work as well in westernized society. This is because there is often a focus on individualism and independence, and by not allowing enough exploration of negative or traumatic experiences can be seen to lead to trivializing these experiences.

Overall, PPT has been received very positively in the positive psychology community, with some wonderful outcomes and results.

## Nossrat Peseschkian's Work and A Brief History of Positive Psychotherapy

Although Seligman is often attributed as being one of the co-founders of PPT, similar therapies focusing on happiness or **quality of life** over emphasis on negatively experienced symptoms pre-date Seligman's work.

Most notably is Nossrat Peseschkian, an Iranian-born psychotherapist, psychiatrist, and neurologist, who set up practice in Germany in the 1960s.

Influenced by humanist psychology, meetings with multiple influential psychologists, and spiritual practitioners, as well as his

own experiences working with clients across more than twenty cultures, Peseschkian wanted to create an integrative therapy model that focused on positive experiences alongside being culturally sensitive.

In the 1970s, Peseschkian began to deliver lectures around his therapy model and published four books based on PPT during this time. In the early 1970s, Peseschkian referred to his model as 'Differentiation Analysis.'

In 1977 he published his first book, '*Positive Psychotherapy,'* and in so doing renamed his approach. During this time, PPT gained further acknowledgment with structured training and the founding of the *Psychotherapeutic Group of Wiesbaden*, *The German Association for Positive Psychotherapy,* and the *Journal of Positive Psychotherapy* in 1979.

Through the 1980s and 1990s, PPT grew in its structure, uses, and acknowledgment as a prevalent theory outside of Germany, with Peseschkian traveling to more than 60 countries to deliver talks and lectures, and opening more than 30 centers. He also continued to publish books, and the '*Wiesbaden Inventory for Positive Psychotherapy and Family Therapy*' was also published in 1988.

In 1994 the *International Center for Positive Psychotherapy* opened its doors, later becoming the *Word Association for Positive Psychotherapy* in 2008. The first effectiveness study of PPT was conducted between 1995 and 1997, concluding that PPT demonstrated a strong therapeutic influence for a range of mental health diagnoses.

Peseschkian wasn't the only one to recognize the benefits of focusing on the positive in therapy. During this time, several other psychologists also explored similar concepts.

Fordyce (1977) developed a 'Happiness' intervention and worked with students to help them utilize a series of 14 tactics aimed at assisting them in developing a better sense of well-being and happiness.

These tactics came with detailed instructions and included things such as socializing, engaging in meaningful work, deepening close relationships with loved ones, and managing expectations. Fordyce found that those students who used the tactics and instructions reported being happier and showed fewer depressive symptoms over a control group.

Fava (1999) and Fava and Ruini (2003) developed their Well-Being Therapy (WBT), which places a focus on building personal mastery across different areas of life, including environmental, personal growth, life purpose, self-acceptance and positive relationships with others.

Alongside Peseschkian's approach, Seligman has been responsible for developing the PPT model alongside more contemporary notions of positive psychology. Where Peseschkian's model is more integrative, cross-disciplinary, and focuses on multi-cultural concepts, more modern PPT practice is primarily based on Seligman's notion of happiness and well-being overall (Seligman, 2002).

It's important to acknowledge that while similar, there are some slight differences between the two approaches.

## Five Benefits of Positive Psychotherapy

The primary goal of PPT is to help individuals better understand the skills and capabilities they have, and ones they might need to develop, to achieve a greater sense of inner balance. This is

achieved by exploring innate resources – physical, emotional, spiritual, and cognitive – the individual already has and may need help tapping into in positive ways.

There are many **benefits of positive psychotherapy** and in approaching our mental health in this way. Below I've explored the top five in more detail:

## 1. Empowers the Individual

As PPT places a strong emphasis on helping the individual to examine their strengths, skills, and capabilities in a positively reframed manner, it increases their sense of empowerment and control over the different areas of their life, as well as their capacity to handle challenges and negative experiences (Rashid, 2014).

The therapist's role in the client-therapist relationship is to encourage the individual to uncover things on their own terms. It places the good with the bad, helping individuals find the balance they need to accept all parts of themselves.

This integration of skills, weaknesses, virtues, vulnerabilities, and strengths helps to build a more balanced perspective rather than reducing individuals to merely their symptoms or what challenges them.

## 2. Positive Reframing of Negative Symptoms and a Focus on Balance

A great benefit of PPT is how it brings the negative in line with the positive. Although it might sound like the model only focuses on positive and dismisses the negative, it focuses more on bringing the two into alignment and balance.

This approach helps individuals to better understand their strengths and skills, where they might have gaps and how these can perpetuate negative feelings or imbalances if not addressed appropriately.

### 3. Acknowledges and Supports Cultural Transitions and Differences

Because PPT encourages empowerment on the individual, it can help them to feel more in control across different areas of their life, even when it might feel that external circumstances are taking over. This has proven especially beneficial for individuals experiencing conflict in multi-cultural environments or relationships.

Bontcheva and Huysse-Gaytandjieva (2013) explored migration and the challenges faced by those who had moved to new countries and cultures. They found that those who applied positive psychotherapy techniques were better able to overcome these challenges, with two-thirds of participants reporting depressive symptoms were entirely resolved.

### 4. Better Management of Expectations and Therapy Outcomes

Another important benefit of PPT is how it acknowledges the importance of the client-therapist relationship, and how the self-directed techniques used are instrumental in helping individuals get the most out of the therapy (Rashid and Seligman, 2018).

With a greater sense of awareness for personal capabilities, strengths, and skills, the individual can understand their mental health journey better, and how they can act to improve this. As a result, therapy expectations are better managed, and individuals see the outcome of PPT as being about more than merely eliminating negative symptoms or feelings.

### 5. Proven to Help a Range of Mental Health Conditions

With its focus on strengths and cultivation of the positive elements of life, PPT has shown to be highly beneficial across a range of mental health conditions including psychosis (Schrank et al., 2016), suicidal ideation (Johnson et al., 2010), depression (Seligman, Rashid, and Parks, 2006, Carver, Scheier and Segerstrom, 2010) and borderline personality disorder (Uliaszek, 2016).

## How Does Positive Psychotherapy Relate to Positive Psychology?

While the two approaches sound very similar, there are some cross-overs in how each tackles individual experiences within therapy. Positive psychology is popularly attributed as being the brain-child of Martin Seligman, developed in 1998, where positive psychotherapy is more commonly attributed to Nossrat Pesechkian, first developed in 1968.

Both approaches draw influences from humanistic and psychodynamic models of psychology.

### What are the similarities and differences between the two?

Both approaches place emphasis on personal development and the importance of tapping into innate resources and strengths to overcome challenges and negatively experience emotions. Both also work on the assumption that we are all inherently good, and need to work hard to uncover when external influences prevent us from becoming the best versions of ourselves.

There are also some slightly nuanced, but very essential differences:

| Positive Psychotherapy | Positive Psychology |
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| Believes all negative experiences can be challenged and reframed in a positive way, as they are essentially opportunities for further growth. | Acknowledges negative experiences and emotions but doesn't necessarily incorporate them in the same way. |
| Focuses more on multi-cultural experiences and the challenges that individuals can face across different cultures – both similar and different. | Has a more Westernised approach to therapy and an individual's experiences. |
| Influenced equally by humanistic and psychodynamic approaches and seeks to integrate the best of both. | Less focused on humanistic models and therapies and less integrative of other psychological approaches. |

Seligman has spoken extensively about both approaches, and how the two are related in specific ways, identifying that positive psychotherapy helps individuals to move past the process of suffering to uncover deeper insights about their wellbeing (Seligman and Wyatt, 2008).

While acknowledging negative or traumatic experiences is a core component of many therapeutic approaches, Seligman has

acknowledged that positive psychotherapy does place a more positive focus when going through this process.

## 3 Positive Psychotherapy Interventions

As touched on briefly, positive psychotherapy has proven beneficial in a range of clinical settings addressing various mental health concerns.

The interventions utilized in PPT are varied, and will often rely on what the individual expresses in the therapy sessions for the therapist to select the ones most appropriate.

A very distinct component of the interventions used in PPT is how it incorporates imagination and intuition as part of the therapeutic

process. Storytelling is another key way PPT encourages individuals to engage with their therapy journey, and this idea of building the self into the stories helps individuals to better articulate their journeys, experiences, challenges, and desires.

Through this process, PPT therapists can begin to introduce adjustments or dive deeper into sensitive topics without seeming to 'attack' the individual.

Therapists can also help those they work with to reframe their experiences and symptoms in positive ways, and then proactively work on rebuilding them positively within their lives (creating better balance). Once individuals can accept all aspects of themselves and begin to see negative experiences in a positive light, they generally no longer repeat those negative experiences.

The specific interventions used in this process have a focus on empowering the individual and providing them with the tools and resources to face up to negative or traumatic experiences, cultivate resilience, and develop better emotional functioning.

These include:

## 1. Practicing Gratitude

Gratitude is a strong cognitive state, generally associated with the idea that you have achieved a personal benefit that wasn't initially or intentionally sought after (Emmons and McCullough, 2003). Feeling gratitude can have a strong re-energizing impact on our emotional well-being and has been shown to lead to greater feelings of happiness and healing.

In therapy, practicing gratitude can begin with making the time to acknowledge all the small everyday things that occur and for which we can feel grateful. Gratitude journals, **worksheets**, and resources

are widely available, and it's a popular intervention in PPT to help show individuals everything they have in their lives to feel grateful for – something many of us often forgets to acknowledge.

## 2. Practicing Forgiveness

Many therapists agree that forgiveness – for the self, others, and general experiences – is a vital part of healing and promoting a greater sense of well-being. Worthington (2003) proposed two core types of forgiveness within clinical/therapy settings:

1. Decisional Forgiveness: Where the individual states a behavioral intent to forgive.
2. Emotional Forgiveness: Where the individual has true emotional acceptance of the situation, experience, or personal feelings that requires forgiveness.

We can utilize decisional forgiveness but still feel emotionally upset, which can lead to further unforgiveness and negative symptoms related to our mental health (Worthington and Scherer, 2007). PPT utilizes the practice of forgiveness as a key intervention, particularly focusing on emotional forgiveness so that individuals feel a complete sense of healing when moving past negative symptoms.

## 3. Practicing Empathy

The PPT approach teaches that all humans are inherently good, and innately want to live meaningful lives and have enriching relationships. Empathy is a core component of this, but it has been shown to routinely fail as an innate ability in several challenging or conflicting scenarios (Zaki & Cikara, 2015).

Most empathy-related interventions build on the notion that we are all capable of empathy, and these interventions support individuals

to focus instead on developing their ability to tap into empathy and target it in specific ways.

One approach utilized by PPT is using the storytelling method to ask individuals to put themselves in another's shoes and describe how they might feel, react or respond to challenging situations, as well as how they might react to positive situations.

## The Positive Psychotherapy Model (inc. Table with Brief Session Descriptions)

Similar to other therapy models, the PPT model focuses on a series of sessions aimed at uncovering ideas, desires, vulnerabilities and strengths, and working through them to reach positive reframing and overall balance between the positive and the negative.

The below outline of sessions is a brief overview of the PPT model. Some versions of this relate more to the approach developed by Pesechkian, and as with all therapy models, there can be slight nuances depending on the therapist and where they practice.

| Session and Topic | Description |
|---|---|
| **Orientation to PPT; Current Positive Resources** | Psychological distress is discussed as a lack of positive resources, such as positive emotions, relationships, meaning, and accomplishment. To explore this, the therapist might use an exercise that encourages the individual to write a one-page, real-life |

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| | story that called for the best in them and has a positive ending. |
| **Individual Character Strengths** | In this session, individual character strengths are explored, and the concept of engagement and flow is introduced. To begin exploring individual character strengths, the individual may be asked to identify what they believe are their signature strengths both in the session and through an online self-report. They may also ask two other close persons to rate their signature strengths. |
| **Signature Strengths & Positive Emotions** | Following on from the last session, signature strengths are discussed in more detail. As an exercise, the therapist may ask the individual to compile a signature strengths profile, which could include setting SMART (specific, measurable, achievable, realistic, and timely) goals. |
| **Good vs. Bad Experiences, Symptoms or Memories** | The concept of how negative experiences and symptoms can be perpetuated is discussed in alignment with positive experiences. |

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| | The therapist might use an exercise that asks the individual to explore a memory or experience that elicited feelings of anger, bitterness, or resentment and how these feelings further perpetuated the negative experience. |
| **Forgiveness** | Forgiveness is explored as a resource to reframe negative symptoms and feelings into more positive emotions.<br>The therapist might use a **letter-writing exercise** that asks the participant to remember a negative experience and to write out a letter of forgiveness towards the perceived transgressor/s of the scenario – themselves included. |
| **Gratitude** | Alongside forgiveness, gratitude is explored as a resource for generating better balance, and to view individual circumstances more positively.<br>The role of positive and negative memories, feelings, and symptoms are discussed with an emphasis on gratitude for all the lessons both of these states have allowed for.<br>The therapist might use gratitude journaling as an exercise to help build |

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| | more focus and awareness of all the things for which the individual is grateful. |
| **Mid-Therapy Check** | At this point, the therapist may follow up on any at-home tasks related to the forgiveness and gratitude sessions, and to revisit any of the previous sessions that may feel unresolved. This is also the opportunity for the individual to discuss their perceived gains or hurdles they might be experiencing so far as an outcome of the sessions.<br>As an exercise, the therapist may seek to explore different ways the individual can overcome any of the hurdles, utilizing their signature strengths uncovered previously. |
| **Satisficing vs. Maximizing** | The therapist may now introduce the two concepts of satisficing (mainly, being 'good enough') and maximizing. The individual may be asked to explore the different ways in life they have not felt 'good enough' and to tell the story of one experience where they did feel good enough, and one where they did not. Again, these can be explored regarding |

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| | the individual's signature strengths. |
| **Hope and Optimism** | The additional concepts of optimism and hope are explored.<br>As an exercise, the therapist may ask the individual to think about a time when they may have felt they lost out on something, only to discover it opened up new opportunities. |
| **Positive Communication** | Various interventions that involve developing positive communication, such as Active-constructive, are explored and referenced in association to the individual's signature strengths. |
| **Signature Strengths of Others** | The importance of recognizing, acknowledging, and associating with the signature strengths of the key people the individual has close relationships with is explored.<br>As an exercise, the therapist may ask the individual to draw up a 'Family Strengths Tree' where the individual asks their significant relationships to complete an online self-report strengths test and identify their signature |

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| | strengths.<br>These can then be discussed in the session. |
| **Savoring** | The concept of savoring is explored, as well as some of the techniques and strategies that can be used to prevent adaptation, along with techniques and strategies to safeguard against adaptation. |
| **Gift of Time and Positive Legacy** | The benefits of kindness, sharing, and helping others are explored and discussed in alignment with therapeutic outcomes.<br>As an exercise, the therapist might ask the individual to make plans for how they might give the gift of their time utilizing their signature strengths. |
| **The Full Life** | In the final session, 'The Full Life' is discussed in terms of what the individual feels they have that leads to this. Therapeutic gains are discussed, focusing on positive emotions, engagement, and meaning. How to keep this momentum going is |

also discussed, and ways of doing this are devised with the individual taking the lead and considering their signature strengths to achieve this.

As mentioned, the above is a brief overview of the sessions that can be included in the PPT model. If you'd like to find out more about the model and detailed descriptions of the sessions, as well as interventions and **positive psychotherapy exercises** that can be used within them, you can find more information through the **Positive Psychology Toolkit**.

### Positive Psychotherapy Resources

As a psychological approach, PPT has grown considerably in popularity over the past decade or so. There is now a wide range of resources, tools, books, and other media to help you either as a therapist or an individual better understand this model and utilize it in productive ways.

## Transactional Analysis

We've all experienced communication breakdowns.

You know the feeling. One minute you're having a normal conversation with someone, and the next you're fighting or one of you has shut down.

In both cases, there's a breakdown. The conversation has failed to achieve its goal, whether it's being heard, solving a problem, feeling connected, making a decision, etc.

**This happens all the time. It takes seconds for a conversation to shift from a positive, connection-driven interaction into a negative one.**

And negative interactions take a toll on our relationships. Studies show that we need 5 positive interactions to make up for every negative interaction we have with someone close to us.

**According to Transactional Analysis, communication breakdowns happen because we're not fully present in our conversations.**

Instead of reacting to the here and now, we're communicating from different 'ego states'. And when these ego states are crossed, conflict happens.

This article will teach you how to use Transactional Analysis to have better, more constructive conversations (and interactions, in general) with the people closest to you.

Part 1 will introduce Transactional Analysis, the different ego states, and common transactions. Part 2 will focus on the 'games we play' and how to change them.

## Transactional Analysis

Transactional Analysis (TA) is a psychological theory, developed by Eric Berne in the 1960s, that helps explain why we think, act and feel the way we do.

TA claims that we can better understand ourselves by **analyzing our transactions** with the people closest to us. Transaction = conversation/interaction between two people.

TA is most effective for understanding: 1) transactions with **people you're close** to, not colleagues or acquaintances and 2) transactions about **sensitive, important topics** such as sex, money, jealousy…pretty much anything that's triggering, i.e. causes a deep-rooted emotional reaction in you or the other person.

**TA is based on 3 principles:**

- We all have **three 'ego states**' (Parent, Adult, and Child)
- We all have **transactions** (with other people, or internally with ourselves)
- We all (unconsciously) **activate our ego states** in our transactions, which can lead to conflict, negative emotions, pain, etc.

Basically, transactional analysis is about identifying which ego states are present in your transactions so that you can become more conscious of your thoughts and behaviors, and ultimately have better, more constructive transactions with the people closest to you.

**Ego states: Parent, Adult & Child**

**We all have all three ego states:** Parent, Adult, and Child. These ego states are made up of consistent feelings and behaviors. *Ego states aren't always negative, see below.

These ego states are being activated all the time, whether we're aware of it or not:

**Parent (rooted in the past)** — Contains the attitudes, feelings, and behavior incorporated from our parents (or any primary caregiver). It involves responding as one of our parents would have: saying what they would have said, feeling what they would have felt, behaving how they would have behaved.

- *nurturing parent:* caring, loving, helping
- *controlling parent:* criticizing, reprimanding, censoring, punishing, etc.

**Adult (rooted in the present)** — Our ability to think and act based on what's happening in the here and now. Think of transactions you have with colleagues or acquaintances. These are usually pretty straightforward, without a lot of emotional triggers.

- A good way to know if your Adult ego state is activated is to examine whether your questions/comments are fueled by compassion and curiosity, or the desire to blame, criticize or prove a point.

**Child (rooted in the past)** — Contains the thoughts, feelings, and behaviors that we experienced as a child.

- *natural child*: curious, creative, open, loving
- *adaptive child*: guilty, afraid, depressed, anxious, envious, prideful, trying to please everyone…you get the picture.

**IMPORTANT:** The adaptive child is one of the most troublesome parts of our personality. It developed as we learned to change (adapt) our feelings and behavior in response to the world around us.

**Understanding ego states**

According to TA, our 3 ego states 'show up' whether we want them to or not, so it's important to be aware of what they 'look' like.

The good news is that this is pretty easy to do. Simply think back and answer the following questions:

- **Child:** When you were a kid what do you remember feeling? What was a theme in your interaction with your parents? Were you always fighting for their attention? Did you feel unconditional love? Did you feel that you needed to prove yourself?

This is what Tony Robbins is getting at when he asks: "Think of the person whose love you craved most: what did you have to be for that person to accept and love you? What did you have to think or do to gain their approval?"

- **Parent:** When you were a kid how do you remember your parents behaving? Were they critical? Distrustful of others? Overly cautious? Reckless? What were their beliefs about the world, money, people, etc.?

Now pay attention to which elements of your Child and Parent ego states you've integrated into your own thoughts, beliefs, and behaviors.

Every person's Parent and Child ego states are different.

For example, when my Child ego state is activated I shut down and can't talk to anybody. Other people's Child may get defensive or lash out. It all depends on the patterns you picked up as a child.

Now, think about the people closest to you. What does your partner's Child ego state look like? What about their Parent?

## Understanding transactions: Complementary, Crossed & Ulterior

According to TA, there are three kinds of transactions: Complementary, Crossed & Ulterior. Part 1 will only focus on Complementary and Crossed transactions. Part 2 will focus on Ulterior transactions.

It's important to realize that there are three parts to each transaction:

1. **What you say** (your activated ego state)

2. **The response (and ego state) you expect to 'receive'**

3. **The response you actually receive**

### Complementary

Complementary transactions = effective and successful communication.

Complementary transactions are when two people's ego states are sympathetic or complementary to one another.

This means that what you say and the response you expect to receive, and actually receive, are aligned.

A complementary interaction is when Person 1 (Parent) speaks to Person 2 (Child), and Person 2(Child) responds to Person 1 (Parent). It's easier to understand with pictures, see below.

### Example 1: Adult — Adult

Money is a trigger topic (at least in my experience) because it's uncomfortable, stressful and emotional to talk about.

A complementary transaction around money would like this:

In this transaction, all is good:

- **Person 1** is curious about something, and asks a question from the Adult ego state, hoping they'll receive an answer from Person 2's Adult ego state.
- **Person 2** responds from his/her Adult ego state.
- **Result:** All good, two Adults are working together to understand a problem, make decisions, etc.

*I'm assuming that Person 1's question is fueled by curiosity, thus coming from the Adult ego state. However, it could be that Person 1's question is actually fueled by a desire to blame or prove a point. In this case, Person 1's 'Parent' ego state is probably being activated, not the Adult.

Either way, the point of transactional analysis is to pay attention to your conversations with the people closest to you. To bring awareness to what roles (ego states) you're both activating and why.

**Example #2: Parent - Child**

Another complementary transaction is Parent -> Child. For example, this can occur when one person is sick and wants to be taken care of by the other person (P)

- **Person 1** feels like shit. Their Child ego state is activated because they want to be taken care of. They expect Person 2 to respond as a Parent.

- **Person 2** understands Persons 1's request and is happy to oblige. Person 2's Parent ego state is activated and they happily take care of Person 1.
- **Result**: All is good. There's a balance of 'giving & receiving' and both parties feel loved.

**How do you know you're having a complementary transaction?**

1. **You feel ok** (i.e. you're not overwhelmed with emotions)
2. **You feel seen and understood**
3. **The conversation can go on forever** (no emotional outbursts, hurt feelings, slamming doors, or conversation stoppers — i.e. "I'm done with this conversation right now"). This means you can actually reason about things, make decisions, create a plan, etc.

**Crossed Transactions**

Crossed transactions happen when Person 1 says something from one ego state, and receives a different response than he/she is expecting.

For example: Back to the money topic

In this transaction, all is NOT good:

- **Person 1** is curious about something, and asks a question from the Adult ego state, hoping they'll receive an answer from Person 2's Adult ego state.
- **Person 2** is triggered. They're Child ego state is activated (they feel criticized or patronize) and they're pissed.

- **Result:** Probably a fight, or an abrupt end to the conversation. Of course it's ok if this happens once in a while, however habitual communication breakdown is harmful to a relationship.

Another example is:

- **Person 1** feels like shit. Their Child ego state is activated because they want to be taken care of. They expect Person 2 to respond as a Parent.
- **Person 2** hears Persons 1, but doesn't see what the big deal is. His/her Adult ego state is activated and they tell Person 1 to rest.
- **Result:** Person 1 probably feels hurt because his/her needs weren't being met. *Again, crossed transactions happen all the time. TA is about bringing awareness to these transactions so we can reduce their negative effect.

**According to TA, all communication breakdowns occur because of a crossed transaction.**

When you're in the middle of a crossed transaction, the only way to get it back to a constructive place is for one, or both of you, to shift ego states.

Usually, it's best to shift (or try very very hard to shift) to the Adult ego state. However, it can vary. You need to be attuned to what's actually happening in a conversation and the needs of each person (hard to do, but possible with practice).

## Dialectic behavior therapy

Dialectical behavior therapy (DBT) treatment is a type of psychotherapy — or talk therapy — that utilizes a cognitive-behavioral approach. DBT emphasizes the *psychosocial* aspects of treatment.

The theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships. DBT theory suggests that some people's arousal levels in such situations can increase far more quickly than the average person's, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels.

People who are sometimes diagnosed with borderline personality disorder experience extreme swings in their emotions, see the world in black-and-white shades, and seem to always be jumping from one crisis to another. Because few people understand such reactions — most of all their own family and a childhood that emphasized invalidation — they don't have any methods for coping with these sudden, intense surges of emotion. DBT is a method for teaching skills that will help in this task.

Components of DBT

- **Support-oriented:** It helps a person identify their strengths and builds on them so that the person can feel better about him/herself and their life.
- **Cognitive-based:** DBT helps identify thoughts, beliefs, and assumptions that make life harder: "I have to be perfect at everything." "If I get angry, I'm a terrible person" & helps people to learn different ways of thinking that will make life more bearable: "I don't need to be perfect at things for people

to care about me", "Everyone gets angry, it's a normal emotion.

- **Collaborative:** It requires constant attention to relationships between clients and staff. In DBT people are encouraged to work out problems in their relationships with their therapist and the therapists to do the same with them. DBT asks people to complete homework assignments, to role-play new ways of interacting with others, and to practice skills such as soothing yourself when upset. These skills, a crucial part of DBT, are taught in weekly lectures, reviewed in weekly homework groups, and referred to in nearly every group. The individual therapist helps the person to learn, apply and master the DBT skills.

**Generally, dialectical behavior therapy (DBT) may be seen as having two main components:**

**1. Individual weekly psychotherapy sessions** that emphasize problem-solving behavior for the past week's issues and troubles that arose in the person's life. Self-injurious and suicidal behaviors take first priority, followed by behaviors that may interfere with the therapy process. Quality of life issues and working toward improving life in general may also be discussed. Individual sessions in DBT also focus on decreasing and dealing with post-traumatic stress responses (from previous trauma in the person's life) and helping enhance their own self-respect and self-image.

Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship[…]. The emphasis is on teaching patients how to manage emotional trauma rather than reducing or taking them out of crises […]. Telephone contact with the individual

therapist between sessions is part of DBT procedures. (Linehan, 2014)

During individual therapy sessions, the therapist and client work toward learning and improving many basic social skills.

**2. Weekly group therapy sessions**, generally 2 1/2 hours a session which is led by a trained DBT therapist. In these weekly group therapy sessions, people learn skills from one of four different modules: interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills are taught.

## The 4 Modules of Dialectical Behavior Therapy

### 1. Mindfulness

The essential part of all skills taught in skills group are the core mindfulness skills.

*Observe, Describe,* and *Participate* are the core mindfulness "what" skills. They answer the question, "What do I do to practice core mindfulness skills?"

*Non-judgmentally, One-mindfully,* and *Effectively* are the "how" skills and answer the question, "How do I practice core mindfulness skills?"

### 2. Interpersonal Effectiveness

The interpersonal response patterns –how you interact with the people around you and in your personal relationships — that are taught in DBT skills training share similarities to those taught in some assertiveness and interpersonal problem-solving classes. These skills include effective strategies for asking for what one

needs, how to assertively say ‘no,’ and learning to cope with inevitable interpersonal conflict.

People with borderline personality disorder frequently possess good interpersonal skills. They experience problems, however, in the application of these skills in specific contexts — especially emotionally vulnerable or volatile situations. An individual may be able to describe effective behavioral sequences when discussing another person encountering a problematic situation, but may be completely incapable of generating or carrying out a similar set of behaviors when analyzing their own personal situation.

This module focuses on situations where the objective is to change something (e.g., requesting someone to do something) or to resist changes someone else is trying to make (e.g., saying no). The skills taught are intended to maximize the chances that a person’s goals in a specific situation will be met, while at the same time not damaging either the relationship or the person’s self-respect.

### 3. Distress Tolerance

Most approaches to mental health treatment focus on changing distressing events and circumstances. They have paid little attention to accepting, finding meaning for, and tolerating distress. This task has generally been tackled by religious and spiritual communities and leaders. Dialectical behavior therapy emphasizes learning to bear pain skillfully.

Distress tolerance skills constitute a natural development from mindfulness skills. They have to do with the ability to accept, in a non-evaluative and nonjudgmental fashion, both oneself and the current situation. Although the stance advocated here is a nonjudgmental one, this does not mean that it is one of approval: acceptance of reality is not approval of reality.

Distress tolerance behaviors are concerned with tolerating and surviving crises and with accepting life as it is in the moment. Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons. Acceptance skills include radical acceptance, turning the mind toward acceptance, and willingness versus willfulness.

### 4. Emotion Regulation

People with borderline personality disorder or who may be suicidal are typically emotionally intense and labile — frequently angry, intensely frustrated, depressed, and anxious. This suggests that people grappling with these concerns might benefit from help in learning to regulate their emotions.

Dialectical behavior therapy skills for emotion regulation include:

- Learning to properly identify and label emotions
- Identifying obstacles to changing emotions
- Reducing vulnerability to “emotion mind”
- Increasing positive emotional events
- Increasing mindfulness to current emotions
- Taking opposite action
- Applying distress tolerance techniques

## Art therapy, Performing Art Therapy

Art therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied

psychological theory, and human experience within a psychotherapeutic relationship.

Art therapy, facilitated by a professional art therapist, effectively supports personal and relational treatment goals as well as community concerns. Art therapy is used to improve cognitive and sensorimotor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change.

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Art therapists are master-level clinicians who work with people of all ages across a broad spectrum of practice. Guided by ethical standards and scope of practice, their education and supervised training prepares them for culturally proficient work with diverse populations in a variety of settings. Honoring individuals'

values and beliefs, art therapists work with people who are challenged with medical and mental health problems, as well as individuals seeking emotional, creative, and spiritual growth. Through integrative methods, art therapy engages the mind, body, and spirit in ways that are distinct from verbal articulation

alone. Kinesthetic, sensory, perceptual, and symbolic opportunities invite alternative modes of receptive and expressive communication, which can circumvent the limitations of language. Visual and symbolic expression gives voice to experience, and empowers individual, communal, and societal transformation.

Performing Art Therapy in Geriatric Care – Presentation Transcript

1. Performing Art Therapy in Geriatric Care Dr. D. Dutta Roy Psychology Research Unit Indian Statistical Institute, Kolkata – 700108 Web :http://www.isical.ac.in/~ddroy E-mail: ddroy @ isical .ac.in Venue: Paripurnata, 12.11.09 Audience: Senior People
2. What is performing art therapy ?
    - Performing art generally includes dance, music, songs, drama in organized fashion. Besides, painting, sculpturing, Yoga, farming etc. are the performing arts.
    - Performing art therapy is the therapeutic process in which performing art therapist tends to
    -
        - explore one’s needs, values, crisis in the life cycle;
    -

- improvise performing art in such a fashion so that client can understand own needs and can develop coping strategy to overcome the crisis.

- In performing art, client is not merely receptive but productive and creative. Therefore, the objective of therapist will be to stimulate the client to understand self and socially accepted coping strategies. It develops adaptability within individual.

3. Role of Performing Art therapist

- Performing art therapist acts as the tool for
- Diagnosis
- Restoring (condition at control)
- Preventing and
- Promoting physical, mental, social and spiritual health.

- It is the process of achieving three layers of consciousness.

4. What happens during PAT ?

- During performing art, individual travels around different layers of consciousness – the outer, inner and inner core layers.
- During traveling, individual understands own crisis in life cycle, underlying reasons and sets own coping strategy.
- It helps individual to find meaning in life, to realize own self and develop high efficacy in cognitive, emotional, psycho motor co-ordination and over all health efficacy.
- It increases desires for life expectancy.
- It controls ageing process.

5. CONSCIOUSNESS PARADIGM Outer Layer: -Missing -Anomalies Inner Layer -Vividness -Orderliness -Complexity
    - Inner Core Layer
    - Harmony with Environment
    - Aesthetics
    - Cleanliness
6. A Journey
    - Rabindrasangeet is a journey from outer layer to inner core through inner layer of consciousness.
    -
        - "Chokher aloy dekhechilem chokher bahire"; (outer layer)
    -

- "Antare aaj dekhbo, jakhan alok nahi re" (inner layer)

- "Dharay jakhan dao na dhara hriday takhan tomay bhara, ekhon tomar apan aloy tomay chahi re" (innercore layer)

7. Playing in the outer layer

- " Ami keboli swapan karechi bapan batase-
- Tai akashkusum karinu chayan hatashe
- Chayar matan milay dharani, kul nahi pay ashar tarani,
- Manaspratima bhasia beray akashe"

" Emni karei jay jadi din jak na, Mon ureche uruk na re mele diye ganer pakhna"

8. Mixing with inner core/Saraswat layer

- " Amar poran jaha chay tumi tai, tumi tai Go toma chhara ar e jogote mor keho nai, keho nai Go.
- Tumi sukh jodi nahi pao, jao sukher sondhane jao ami tomare peyechhi hridhoymajhe, ar kichhu nahi chai go.
- Ami tomar birohe rohibo bileen, tomate koribo baas dhirgho dibos dhirgho rojoni, dirgho borosh-maas."

9. The Second stage

- The journey is not very smooth. Lot of ideas are broken, built and rebuilt.

- “ Tomay niye khelechilem khelar gharete khelar putul bhenge geche pralayy jhaarete Thak tabe sei kebol khela, hok -na ekhon praner mela- tarer bina bhanglo, hriday-binay gahi re. "

10. Case Study 1: Where all fail, Rabindrasangeet acts

11. Response control of OCD

- A woman of 52 years old came to me with complaint of OCD to dirt. Patient reported her inability to control washing compulsion. For last 30 years, she regularly went to toilet for washing and cleaning hands. She always closed her hands tightly so that her hands would be completely cleaned. Before visit to me, she was treated by many psychiatrists and one psychologist. No notable changes are noticed except long time sleep.

12. Patient’s behaviour

- Very inhibitive;
- Hand clasping tightly;
- Strong resistance to open clasping;
- Non-cooperative to participate;
- Not able to administer any available psychological tests.

13. Analysis of patient

- Patient is searching for dirt in the outer layer.
- In the inner layer, dirt is perceived as threatening;

- Patient wants to move away from inner to inner core layer. For the same, she spends most of the time in worshipping the God and keeping cleanliness.
- She is not happy with soaping hands as this can not help her to reach at the innercore layer of consciousness.
- This results approach – avoidance conflict.
- (Approaching to the soap in order to avoid dirt, again few soaping is not sufficient, so more soaping is required ).

14. Analysis of family

- Repeated soaping consumes more water;
- Family assumes that it is unreasonable but patient assumes it as reasonable ;
- Family member is not aware of consciousness dynamics playing inside the patient.

15. Therpeautic analysis

- Target: Preventing clasping hands;
- Consciousness model:
- 
    - Outer layer : Dirt perception;
- 
    - Inner layer : Dirt as threat;
- 
    - Innercore : Feeling of cleanliness;

- Currently, patient is moving around outer and inner layers only.
- Therapeautic target: Providing her Feeling of cleanliness.
- Rabindrasangeet is non-dirt area;
- Explore the song suitable for feeling of non-dirt area;

16. Session-1

- In the first session , patient was highly inhibitive to reveal herself. Due to difficulty in rapport establishment. I started singing – "Ananda loke, mangala loke" (moving to spiritual land).
- Suddenly, she started singing with me in very low voice;
- I paid my attention to her and started moving the hands keeping with the rhythm and waves of the song loudly. She participated into my hand movement and sang the song loudly.

17. Session-2

- In the 2nd session after 6 days, the client sang with me same song by standing. She moved her hands above head when she sang " Grahataraka chandra tapana byakula drutabege" (the planets, satellites are moving speedily). It is noted that her hands now completely opened.

18. Session-3

- In the 3rd sitting, patient reported that she alone practiced two songs

- "Ektuku chona lage…." (feeling light touch), and
- "Eto din je bosechinu" (waiting for long days) at home. Finally, she sang with me both songs alongwith Ananda loke, danced and she never closed her hands.
- Termination : Patient herself is able to prevent stopping hand clasping.

19. Searching Principle : Growth of inquisitiveness Feeling of scattered impulses,needs etc. Searching cues Does it give meaningful pattern ? N Y
20. Geriatric assessment
21. Geriatric Disorders
    - Organic Disorders : Dementia, Delirium
    - Psychological Disorders :
    - Neurotic (Anxiety disorder, Phobic disorder, Conversion reaction, Dissociative Reaction, Obsessive Compulsive disorder, Depression, Hypochondriasis)
    - Psychotic (Schizophrernia, Manic-Depressive Disorder, Paranoia)
    - Substance abuse
    - Sexual disorder
22. History
    - Modern geriatrics in the United Kingdom really began with the "Mother" of Geriatrics, Dr. Marjorie Warren . Warren emphasized that rehabilitation was

essential to the care of older people. She developed the concept that merely keeping older people fed until they died was not enough- they needed diagnosis, treatment, care and support . She found that patients, some of whom had previously been bedridden, were able to gain some degree of independence with the correct assessment and treatment.

- Another "hero" of British Geriatrics is Bernard Isaacs , who described the " giants " of geriatrics: incontinence, immobility, impaired intellect and instability. Isaacs asserted that if you look closely enough, all common problems with older people relate back to one of these giants

23. Geriatric Psychology for the Care givers

- To understand different principles leading to formation of different symptoms of geriatric disorders.
- Biological Paradigms : Brain mapping, Loss or injury
- Psychological Paradigms : Psychodynamic, Learning, Cognitive
- To understand principles of Psychology in order to improve quality of life of the elderlylyly people.
- Counseling, Psychotherapy, Individual and community care.

24. BIOLOGICAL PARADIGM

- BRAIN MAPPING
- LOSS OF BRAIN FUNCTIONS

25. Brain Mapping

- Frontal Lobe
    - How we know what we are doing within our environment ( Consciousness ). How we initiate activity in response to our environment. Judgments we make about what occurs in our daily activities. Controls our emotional response. Controls our expressive language. Assigns meaning to the words we choose. Involves word associations. Memory for habits and motor activities.
- Parietal Lobe
    - Location for visual attention. Location for touch perception. Goal directed voluntary movements. Manipulation of objects. Integration of different senses that allows for understanding a single concept.
- Occipital Lobe
    - Vision
- Temporal Lobe
    - Hearing ability Memory acquisition Some visual perceptions Categorization of objects.
- Brain Stem
    - Breathing Heart Rate Swallowing Reflexes to seeing and hearing ( Startle Response ). Controls sweating, blood pressure, digestion, temperature ( Autonomic Nervous System ). Affects level of

alertness. Ability to sleep. Sense of balance ( Vestibular Function ).

- Cerebellum
-
    - Coordination of voluntary movement Balance and equilibrium Some memory for reflex motor acts.

26. Loss of Brain Functions

- Frontal Lobe
    - Loss of simple movement of various body parts ( Paralysis ). Inability to plan a sequence of complex movements needed to complete multi-stepped tasks, such as making coffee ( Sequencing ). Loss of spontaneity in interacting with others. Loss of flexibility in thinking. Persistence of a single thought ( Perseveration ). Inability to focus on task ( Attending ). Mood changes ( Emotionally Labile ). Changes in social behavior. Changes in personality. Difficulty with problem solving. Inablility to express language ( Broca's Aphasia ).
- Parietal Lobe
    - Inability to attend to more than one object at a time. Inability to name an object ( Anomia ). Inability to locate the words for writing ( Agraphia ). Problems with reading ( Alexia ). Difficulty with drawing objects. Difficulty in distinguishing left from right. Difficulty with doing mathematics ( Dyscalculia ). Lack of awareness of certain body parts and/or

surrounding space (Apraxia) that leads to difficulties in self-care. Inability to focus visual attention. Difficulties with eye and hand coordination.

- Occipital Lobe
-
    - Inability to attend to more than one object at a time. Inability to name an object ( Anomia ). Inability to locate the words for writing ( Agraphia ). Problems with reading ( Alexia ). Difficulty with drawing objects. Difficulty in distinguishing left from right. Difficulty with doing mathematics ( Dyscalculia ). Lack of awareness of certain body parts and/or surrounding space (Apraxia) that leads to difficulties in self-care. Inability to focus visual attention. Difficulties with eye and hand coordination.
- Temporal Lobe
    - Difficulty in recognizing faces ( Prosopagnosia ). Difficulty in understanding spoken words ( Wernicke's Aphasia ). Disturbance with selective attention to what we see and hear. Difficulty with identification of, and verbalization about objects. Short-term memory loss. Interference with long-term memory Increased or decreased interest in sexual behavior. Inability to catagorize objects ( Catagorization ). Right lobe damage can cause persistant talking. Increased aggressive behavior.

27. Comprehensive geriatric assessment

- Identification : Age, sex, brought in by whom, chief complaint
- Source of History (include reliability rating) : Patient, caregiver, family, friends Medical records, Previsit questionnaire
- History of Present Problems/Condition
- Medications – old medication lists, herbal/alternative medications , Allergies/Adverse Drug Reactions : Name specific medications and characterize specific allergic/adverse drug reaction for each medication
- Habits : tobacco, recreational drugs
- Social History : Education, Marital Status/Children, Household members, Activities/Exercise, Travel, Occupational History/Toxin Exposures, Diet, Caffeine, Sexual Activity, Caregiver roles
- Past Medical History : (ask about previous medical records, old lab/imaging/study reports)
- Family History : Heart disease, cancer, diabetes, TB, HTN, mental health, Alzheimer's disease
- Care Resources : past and present Home Health, Case Management, etc.
- Personal History : Environment, Reverse developmental milestones

28.

- Review of Systems :

- General : fevers, chills, malaise, fatiguability, night sweats, weight changes
- Neurologic : syncope, seizures, weakness, paralysis, abnormal sensation/coordination, tremors, memory loss
- Psychiatric : depression, mood changes, difficulty concentrating, nervousness, tension, suicidal ideation, irritability, sleep disturbances
- Sensory Functions : visual changes, hearing changes, neuropathy, balance/coordination
- Motor Functions : gait, falls, ataxia
- Diet : preferences, restrictions (religious, allergic, disease), vitamins/supplements, caffeine, food/liquid intake diary , "look in fridge test" , who prepares/obtains food
- Skin : rash/eruption, itching, pigmentation, excessive sweating, nail/hair abnormalities
- Head : Headaches, dizziness, syncope, severe head injuries, loss of consciousness
- Eye : visual changes, blurring, diplopia, photophobia, pain, eye medication use, eye trauma, FH of eye disease
- Ears : hearing loss, pain, discharge, tinnitus, vertigo
- Nose : sense of smell, obstruction, epistaxis, postnasal drip, sinus pain, rhinorrhea
- Oral : hoarseness, sore throat, gum bleeding/soreness, tooth abscess/extraction, ulcers, taste changes

Comprehensive geriatric assessment

29.

- Cardiac/Peripheral Vascular : Chest pain, palpitations, dyspnea, orthopnea, edema, claudication, HTN, previous MI, exercise tolerance, previous cardiac studies
- Pulmonary : pleuritic pain, dypsnea, cyanosis, wheezing, cough/sputum, hemoptysis, TB exposure, previous CXR's
- Gastrointestinal : appetite, digestion, dysphagia, heartburn, nausea, vomiting, hematemesis, diarrhea, constipation, stool changes, flatulence, hemorrhoids, hepatitis, jaundice, dark urine, history of ulcers/gallstones/polyps/tumors, previous X-rays
- Renal/Urinary :dysuria, flank/suprapubic pain, urgency, frequency, nocturia, hematuria, polyuria, hesitancy, dribbling, force of stream changes, STD's
- Hematologic : anemia (dizziness/fatigue/dyspnea), easy bruising/bleeding, blood cell abnormalities, transfusions
- Lymphatic : lymph node enlargement/tenderness
- Endocrine/Metabolic : thyroid enlargement/pain, heat/cold intolerance, unexplained weight change, diabetes, polydipsia, polyuria, facial/body hair changes, increased hat/glove size, striae
- Musculoskeletal : joint stiffness, pain, limited ROM, swelling, redness, heat, bone deformity

- Sexual : libido, intercourse frequency, sexual difficulties, impotence
- Gynecologic : itching, last Pap smear, menopause age
- Breasts : pain, tenderness, discharge, lumps, mammograms, self-breast exams

Comprehensive geriatric assessment

30. Geropsychiatric Mental Status Exam

- Most of this exam is observed through the interview conversation with patient
- General Appearance/Behavior: Grooming and hygiene, unusual movements, attitude, psychomotor activity, eye contact
- Affect: (external range of expression) flat, blunted, labile, full/wide range
- Mood: (internal emotional tone) dysphoric, euphoric, angry, euthymic, anxious
- Thought Processes: Language (quality/quantity of speech), tone, associations, speech fluency Note presence of: pressured speech, poverty of speech, blocking, flight of ideas, loosening of associations, tangentiality, Circumstantiality, echolalia, neologisms, clanging, perseveration, ideas of reference
- Thought Content: note hallucinations, delusions, illusions, derealization, depersonalization, suicidal or homicidal ideation

- Cognitive: (mostly covered by psychometric tests )level of consciousness, orientation
- Insight: the patient's understanding of his or her problems and implications of these problems
- Judgment: based on history of patient's decision making abilities

31. Geriatric care by the caregiver

- I) Social Information II) Caregiver Information III) Patient's Health IV) Head Injury V) Activities of Daily Living VI) History of Falls VII) Vision VIII) Hearing IX) Dentition X) Bowel/Bladder XI) Sexuality XII) Nutrition XIII) Communication XIV) Usual daily activities (with exercise) XV) Sleeping XVI) Finances XVII) Home Safety Checklist XVIII) Current Medications XIX) Care resources/agencies

32. Geriatric care by Psychologist

33. Counselling VS Psychotherapy

- Counselling
- A brief treatment focusing on patient's current problems.
- Helping people who have the capacity to cope in most circumstances, who are experiencing temporary difficulties or in a psychosocial transition.
- Psychotherapy
- Psychotherapy is more concerned with the resolution of longstanding personal issues and may be either brief or long term.

- When issues are more symptomatic of something deeper.

34. Why Psychotherapy ?

- It helps aged to deal with those issues and the emotional problems surrounding them and to understand their behavior on others. In addition to improving interpersonal relations psychotherapy increases self esteem and self confidence, decreases feelings of helplessness and anger and improves the quality of life. Psychotherapy of the aged has the general aim of assisting the old person to have minimal complaints to help him or her make and keep fresh of both sexes, and to have sexual relationship where there is still interest and capacity. Psychotherapy helps relieve tension of biological and cultural origins and helps old persons work and play within the limits of their functional status and as determined by their past training activities and self concept in society.

35. Psychodynamic Paradigm

- Pathology of elderly people is due to conflict between structures of mind – Id, Ego and Super Ego.
- Study the pathology in terms of energy processing from Unconscious to conscious through Pre-conscious.
- Psychosexual stages
- Oral, Anal, Phallic,Genital and Latency
- Study it in terms of Ego-defense mechanisms – Regression, Repression, projection, rationalization, displacement, reaction formation etc.

36. Neo-Freudian

- ADLER
- Study abnormal behavior in terms of
- one's failure in striving for perfection,
- Organ Inferiority, Psychological inferiority.
- Defenses
    - Compensation
    - Superiority Complex
- ERIKSON
- Abnormality is due to one's failure in handling crisis of earlier stage.
- Stage One Oral-Sensory: from birth to one, trust vs. mistrust, feeding;
- Stage Two Muscular-Anal: 1-3 years, autonomy vs.doubt, toilet training;
- Stage Three Locomotor: 3-6 years, initiative vs.inadequacy, independence;
- Stage Four Latency: 6-12 years, industry vs.inferiority, school;
- Stage Five Adolescence: 12-18 years, identity vs.confusion, peer relationships;
- Stage Six Young Adulthood: 18-40 years, intimacy vs.isolation, love relationships;

- Stage Seven Middle Adulthood: 40-65 years, generativity vs.stagnation, parenting;
- Stage Eight Maturity: 65 years until death, integrity vs.despair, acceptance of one's life.

37. Psychodynamic Counseling

- Psychodynamic therapists make genetic links between early childhood experiences and deal patient's current character structure and symptomatology. The patient's emotional response to the therapist (transference) and the therapist's emotional response to the patients (counter transference) are also sources of learning. Key patterns of feeling and behaving from early childhood are repeated or 'transferred' on to the people in the patient's adult life including the therapist.

38. Geriatric care by Performing art therapist

39. Performing art acts as tool for diagnosis and therapy

40. Dance,song and drama make your body fit

41. Social dancing

- Social dancing increases feeling of generativity and reduces stagnation in life;
- It reduces feeling of loneliness;
- It provides social support and care;
- It encourages life expectancy
- It contributes to the longevity of the dancers, giving them something to enjoy and focus upon – to live for.

- it alleviates social isolation and quite literally helps take away the aches and pains associated with older age."

Expressive Arts Therapy

**Expressive arts therapy** is a multimodal approach to therapy similar to its cousins drama therapy and music therapy. Expressive arts therapy may incorporate writing, drama, dance, movement, painting, and/or music. People utilizing expressive arts therapy are encouraged by a qualified therapist to explore their responses, reactions, and insights through pictures, sounds, explorations, and encounters with art processes. A person is not required to have artistic ability to use or benefit from expressive arts therapy.

## HISTORY OF EXPRESSIVE ARTS THERAPY

Relatively new in its formation, expressive arts therapy began circa 1970 at the Leslie College Graduate School in Cambridge, Massachusetts. Paolo Knill, a leader in the field, founded the International Network of Expressive Arts Therapy Training Centers and, in 1984, began the ISIS European Training Institutes. Expressive arts therapy was formed as a distinct practice alongside the modalities at the root of its creation. It utilizes all expressive modalities such as art, music, drama, and dance therapies. Although expressive arts therapists are not experts in all of these areas (many have multiple proficiencies), they typically possess the sensitivity and ability to grasp the intermodal technique.

## EXPRESSIVE ARTS THERAPY PROCESS

Use of the expressive arts multiplies the avenues by which a person in therapy may seek meaning, clarity, and healing. It deepens and transcends traditional talk therapy by acknowledging that each

person's process is unique. While one individual may like talk therapy, another person may prefer to use journaling, movement, art, or a combination of different experiences during therapy.

The accessibility of expressive arts therapy is due to the focus being not on artistic outcomes but rather on the process of creating. A person who utilizes expressive arts therapy is not required to have any artistic ability. Rather, it is through the use of the individual's senses that the imagination can process, flourish, and support healing. As such, the process is often referred to as "low skill, high sensitivity."

Each creative arts modality is unique, and the use of each is carefully considered by each expressive arts therapist. For example, journaling might be an appropriate expressive outlet for someone new to therapy. On the other side of the spectrum, a person who has already established a strong therapeutic relationship with his or her therapist may appreciate the use of movement or drama. Careful use of each modality is determined by the strength, timing, pacing, and readiness of the person in therapy. Different modalities may be used at any point throughout the therapeutic process as needed. Homework may also be issued for the person in therapy to complete between sessions.

## CONDITIONS TREATED WITH EXPRESSIVE ARTS THERAPY

Expressive arts therapy may be used as a part of the treatment strategy for a wide variety of behavioral, emotional, and mental health conditions. These include:

- Attention-deficit hyperactivity
- Developmental disabilities

- Eating disorders
- Traumatic brain injury
- High levels of stress
- Anxiety
- Depression
- Posttraumatic stress
- Chronic medical illnesses
- Social challenges

## EXPRESSIVE ARTS THERAPY TECHNIQUES

Many definitions of expressive arts therapy mention its use of distinct features such as music, movement, play, psychodrama, sculpture, painting, and drawing. If necessary, though, therapists may choose to combine several techniques in order to provide the most effective treatment for the individual in therapy.

Popular therapeutic approaches may involve the use of various drawing and art techniques, including:

- Finger painting
- The squiggle drawing game (sometimes used in other therapeutic approaches, especially with children)
- Mask making
- The blob and wet paper technique
- The kinetic family drawing technique

To illustrate, finger painting may be used as a form of projective play wherein the therapist takes note of the types of lines drawn, the colors used, as well as the work rate and rhythm of the person in treatment.

In a typical session the therapist will describe the process, but will not suggest a specific topic or the colors to be used. Instead, the therapist may provide broad instructions such as “paint something important to you” or “paint a picture of a dream you had.” The therapist then observes the content being produced and the behavior of the person in therapy. Once the picture is finished, the therapist will ask the affected individual to tell a story about the painting.

Finger painting has proven effective in the treatment of children with behavioral issues or other related mental health issues. Through consistent use of this technique, therapists may be able to learn about a child’s personality traits, motor skills, and inner world.

## EXPRESSIVE ARTS THERAPY RESEARCH

The therapeutic impact of expressive arts therapy is focused on four major areas:

- Expression
- Imagination
- Active participation
- Mind-body connection.

Studies indicate that music may help individuals experiencing a wide range of social, developmental, and behavioral issues grow in self-awareness and self-confidence and learn new skills and concepts. Expressive arts therapy has also successfully helped

children experiencing hyperactivity or social anxiety to control impulsive and aggressive behaviors. Though evidence from empirically valid studies is limited, expressive arts therapy has been used to help individuals with disordered eating habits to explore issues regarding body image, self-esteem, social isolation, and depression.

People with medical illnesses may also benefit from expressive arts therapy. Past research has studied how creating artistic photographs may help people cope with the distress of hospitalization. Another study concluded elderly men and women who are part of an active choir report better health, less doctor visits, fewer falls, and less medication use than peers who are not part of an organized arts program. Finally, another body of research on children with cystic fibrosis who took part in a creative arts support program found the children learned how to better express themselves, reduce stress, and find meaning in their current health situation.

## HOW ART THERAPY DIFFERS FROM EXPRESSIVE ARTS THERAPY

Modalities such as art therapy, music therapy, poetry therapy, dance/movement therapy, and expressive arts therapy are all examples of creative arts therapy. While the majority of these disciplines are based in a single art modality, however, expressive arts therapy integrates therapeutic tools and techniques from many different art forms. The combination of a variety of arts-based therapeutic modalities creates a new approach which is distinct from its individual components. Certified expressive arts therapists rely on their creativity and training in order to decide which modality should be utilized at a particular time. Expressive arts therapists

may even employ techniques from a range of other modalities in a single therapy session.

The focus of expressive arts therapy is on the therapeutic effect of the creative experience, and it highlights the human capacity to transform thoughts, emotions, and experiences into tangible shapes and forms. The approach is described as “integrative” when different art techniques are intentionally used in combination with traditional medicines to promote improved health.

## TRAINING FOR EXPRESSIVE ARTS THERAPISTS

Training to be an expressive arts therapist requires at least a master’s degree in counseling with a concentration in expressive arts therapy from an accredited university. Additionally, some institutions offer certificate programs or studies in expressive arts for those who wish to use the expressive arts in related fields such as coaching, consulting, and education. Bachelor’s and PhD options are available, while certification and training continues to grow internationally.

For a list of current available resources, please visit the International Expressive Arts Therapy Association (IEATA), which highlights graduate training programs, certificates, and professional development programs in expressive arts therapy. Those wishing to access this type of therapy are encouraged to find a therapist certified in expressive arts therapy.

## LIMITATIONS OF EXPRESSIVE ARTS THERAPY

One of the major criticisms of expressive arts therapy is the fact that the primary reason for healing is not clearly discernible. It is not clear whether healing occurs from the creative process or if it is due to positive interactions with the therapist. As currently published

studies tend to focus on immeasurable qualitative benefits, a lack of empirical evidence in support of the effectiveness of the approach is a concern.

## Family therapy

We all start this life with a family, whether that family is composed of blood relatives, adopted parents, a close-knit neighborhood, or a foster family. This family that we acquire when we are born influences every aspect of our lives, from our first moments to our last.

Our family affects who we are and who we become, for better and for worse. We learn our vocabulary, our habits, our customs and rituals, and how to view and observe the world around us.

We also learn how to love and how to interact with others from these first important relationships.

If we are born into a healthy family with healthy relationships, we are likely to learn how to maintain healthy relationships. If we are born into a dysfunctional family that struggles to connect, we may also struggle to connect with others.

While it is certainly unlucky to be born into the second kind of family, it’s not an unchangeable situation. Nearly all families deal with some sort of dysfunction at one time or another, yet most families retain or regain a sense of wholeness and happiness.

Family therapy offers families a way to do this—a way to develop or maintain a healthy, functional family.

Family therapy is a type of psychological counseling (psychotherapy) that can help family members improve communication and resolve conflicts.

Family therapy is usually provided by a psychologist, clinical social worker or licensed therapist. These therapists have graduate or postgraduate degrees and may be credentialed by the American Association for Marriage and Family Therapy (AAMFT).

Family therapy is often short term. It may include all family members or just those able or willing to participate. Your specific treatment plan will depend on your family's situation. Family therapy sessions can teach you skills to deepen family connections and get through stressful times, even after you're done going to therapy sessions.

Family therapy can help you improve troubled relationships with your partner, children or other family members. You may address specific issues such as marital or financial problems, conflict between parents and children, or the impact of substance abuse or a mental illness on the entire family.

Your family may pursue family therapy along with other types of mental health treatment, especially if one of you has a mental illness or addiction that also requires additional therapy or rehabilitation treatment. For example:

- Family therapy can help family members cope if a relative has a serious mental illness such as schizophrenia — but the person who has schizophrenia should continue with his or her individualized treatment plan, which may include medications, one-on-one therapy or other treatment.
- In the case of addiction, the family can attend family therapy while the person who has an addiction participates in

residential treatment. Sometimes the family may participate in family therapy even if the person with an addiction hasn't sought out his or her own treatment.

Family therapy can be useful in any family situation that causes stress, grief, anger or conflict. It can help you and your family members understand one another better and learn coping skills to bring you closer together.

**How you prepare**

You can ask your primary care doctor for a referral to a therapist. Family members or friends may give recommendations based on their experiences. You also can ask your employee assistance program, clergy, or state or local mental health agencies for suggestions for therapists.

Before scheduling sessions with a therapist, consider whether the therapist would be a good fit for your family. Here are some factors to consider and questions to ask:

- **Education and experience.** What is your educational and training background? Are you licensed by the state? Are you accredited by the AAMFT or other professional organizations? Do you have specialty training in family psychotherapy? What is your experience with my family's type of problem?
- **Location and availability.** Where is your office? What are your office hours? Are you available in case of emergency?
- **Length and number of sessions.** How long is each session? How often are sessions scheduled? How many sessions should I expect to have?

- **Fees and insurance.** How much do you charge for each session? Are your services covered by my health insurance plan? Will I need to pay the full fee upfront? What is your policy on canceled sessions?

**What you can expect**

Family therapy typically brings several family members together for therapy sessions. However, a family member may also see a family therapist individually.

Sessions typically take about 50 minutes to an hour. Family therapy is often short term — generally about 12 sessions. However, how often you meet and the number of sessions you'll need will depend on your family's particular situation and the therapist's recommendation.

**During family therapy, you can:**

- Examine your family's ability to solve problems and express thoughts and emotions in a productive manner
- Explore family roles, rules and behavior patterns to identify issues that contribute to conflict — and ways to work through these issues
- Identify your family's strengths, such as caring for one another, and weaknesses, such as difficulty confiding in one another

**Example: Depression**

Say that your adult son has depression. Your family doesn't understand his depression or how best to offer support. Although you're worried about your son's well-being, conversations with your son or other family members erupt into arguments and you feel

frustrated and angry. Communication diminishes, decisions go unmade, family members avoid each other and the rift grows wider.

In such a situation, family therapy can help you:

- Pinpoint your specific challenges and how your family is handling them
- Learn new ways to interact and overcome unhealthy patterns of relating to each other
- Set individual and family goals and work on ways to achieve them

**Results**

Family therapy doesn't automatically solve family conflicts or make an unpleasant situation go away. But it can help you and your family members understand one another better, and it can provide skills to cope with challenging situations in a more effective way. It may also help the family achieve a sense of togetherness.

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What is Applications of theories of motivation and learning in School Factors in educational achievement Teacher effectiveness Guidance in schools: Needs, organizational set up and

techniques Counselling: Process, skills, and techniques?

## Applications of theories of motivation and learning in School

In a couple of previous posts I briefly touched on theories of motivation and on how they can be tapped into to raise student achievement. In particular I concerned myself with a relatively unknown and yet powerful catalyst of motivation, self-efficacy, or expectancy of success, which, if nurtured regularly and adequately in the classroom can majorly impact learning. In this post I will very concisely outline the main principles underpinning other influential motivational theories and how I deploy them in my every day teaching in an attempt to enhance my students' motivation.

Here is a **very minimalistic** overview of 8 of the 20 theories of motivation I brainstormed before writing this article. Please note that their tenets and implications for the classroom have been overly simplified; hence, if you are keen to apply them to your specific teaching context, you may want to find out more about them.

1. **Cognitive dissonance**

Cognitive dissonance occurs when there is an unresolved conflict in our mind between two beliefs, thoughts or perceptions we hold about a given subject. The level of tension resulting from such conflict will be a function of:

- How strong the conflict is between the two dissonant thoughts;
- How important the issue they relate to are to a specific individual or group;

- How difficult it is to rationalize (justify through logical or pseudo-logical reasoning) the dissonance.

Cognitive dissonance is a very powerful motivator which, as I shall discuss in a future post, is often used in transformational change programs both in the business and educational world. The reason why it is so powerful is because, when used effectively, Cognitive dissonance creates a sense of discomfort in an individual which in order to be resolved results in one of two outcomes:

- The individual changes behavior (possibly replacing the existing behavior with the newly modelled one);
- The individual does not adopt the new behavior and justifies his/her behaviour by changing the conflicting cognition created by the new information, instead.

Implications for the classroom: Whenever you want to change a student's attitude, first identify the beliefs at the heart of that attitude; when you have a fairly clear picture induce cognitive dissonance by producing powerful information and arguments which counter those beliefs. The degree of cognitive dissonance should be as high as possible for the attitudinal change we purport to bring about to be effective. For example, when dealing with a misbehaving child, to simply tell them off for what they did will be way less effective than raising their awareness of the ways their conduct affected others negatively and explaining why is morally/ethically wrong. Or, to impose a new methodology to one's team of teachers by saying it is more effective than the one currently in use by merely providing statistics from a few research studies which point to its greater effectiveness will not be as powerful as explaining to them **why the old approach is failing the target students and the new can more effectively address the**

**identified shortcomings.** Another example in the realm of language learning: many foreign language students in England hold negative views about the country(i-es) where the target language is spoken. If one wants to change such attitudes one may want to first find out what beliefs are at the root of those attitudes (e.g. are they xenophobic stereotypes?); then in a lesson or series of lesson (at the beginning of the year, maybe?) provide objective and solid reasons to prove that those beliefs are indeed false using supporting evidence which will resonate with the students' sub-culture, thereby creating cognitive dissonance. Research suggests that over-using statistics may be detrimental and that engaging the target students in a discussion on the issues-in-hand after the new information has been provided, will enhance the chances of attitudinal change to occur. This process may induce the learners to restructure their cognition.

2. **Drive reduction theory**

This theory is centred on the notion that we all have needs that we attempt to satisfy in order to reduce the tension or arousal they cause. **The internal stimuli these needs produce are our main drives in life**. There are Primary drives which refer to basic needs (food, sleep, procreation, etc.) and Secondary drives which refer to social identity and personal fulfillment.

As we act on our needs we are conditioned and acquire habits and subconscious responses. So, for example: when a child needs to feel good about himself, he may recite a poem, sing a song, perform a dance or other 'feats' to his parents knowing he is going to get some recognition. Whenever he needs recognition in other contexts, this individual will possibly use the same tactics in order to get the same response from any other figure of authority – including teachers.

When the driven action does not satisfy his needs or the enacting of drives is frustrated, negative emotions (e.g. anxiety) arise. To go back to the previous example: if the boy is looking for a chance to show off to an authority figure his 'skills' but he is not given the opportunity to do so, he will feel frustrated, angry and/or unappreciated – a very common scenario in school, often dismissed as the child being 'naughty' or 'unruly'.

Implications for the classroom: find out what drives your students, especially the difficult ones. Instead of approaching the problem by 'punishing' them, have a one-on-one chat with them and try to discover what is that they find fulfilling and see if you can find opportunities in your lessons for them to enact their drives. For instance, if you have a student passionate about drama who does not seem to enjoy language learning, ask them to contribute their acting skills by myming vocabulary or sentences in lessons or setting up a mini-production in the target language.

3. **Attribution theory**

When we make a mistake or 'fail' at something we tend to go through a two-step process. We first experience an automatic response involving **internal attribution** (i.e. the error is our fault); then a conscious, slower reaction which seeks to find an alternative **external attribution** (e.g. the error is due to an external factor). This is because we all have a vested interest in 'looking good' in our own eyes – a sort of survival mechanism. This type of response, however, is unlikely to lead to self-improvement, as it results in an individual not addressing the real cause of their error/bad performance in the future. Roesch and Amirkham (1997) found that more experienced and successful athletes made more self-serving attributions which lead to identifying and addressing the internal causes of their performance errors.

Implications for the classroom: when dealing with students who complain about not progressing because the subject, skill or task is too hard for them, show them – where applicable – that the reasons why they are not improving is not intrinsic in the nature of that subject, skill or task , but has more to do with other factors under his/her control (e.g. the study habits, such as lack of systematic revision). This will create cognitive dissonance and may have an impact on their attitude, **especially if they are shown strategies that may help them improve in the problematic area(s) of their learning**. The afore mentioned research by Roesch and Amirkham (1997) and their findings could be drawn upon and discussed with your students to reinforce the point; I often do, citing the example of famous athletes the students admire and pointing out how they learn from their mistakes by watching videos of themselves playing a match over and over again or asking peers/experts for feedback in order to identify and address their shortcomings.

4. **Endowed progress effect**

When people feel they have made some progress towards a goal, they will feel more committed towards its achievement. Conversely, people who are making little or no progress are more likely to give up early in the process. In my work with very low achieving 'difficult' students when I operated in challenging inner-city-area schools,sitting with them at the beginning of a task and guiding them through open questioning often 'did the trick' where threatening them with sanctions had failed miserably.

Implications for the classroom: Whatever the task you engage your students in, ensure that they all experience success in the initial stages. This may call for two approaches which are not mutually exclusive: (1) design any instructional sequence in a 'stepped'

fashion, with ‘easy’ tasks that become gradually more difficult; (2) provide lots of scaffolding (support) at the initial stages of teaching.

5. **Cognitive Evaluation Theory**

When looking at a task, we assess it in terms of how well it meets our need to feel competent and in control. We will be intrinsically motivated by tasks we believe fall in our current level of competency and ‘put off’ by those which we deem we will do poorly at. This issue is often more about self-perception of one’s levels of competency than objective truth.

Implications for the classroom: we need to ensure that before engaging students in challenging tasks that they may perceive as being beyond their levels of competence we prepare them adequately, cognitively and emotionally. For instance, in language learning, before carrying out a difficult listening comprehension task, students should be exposed several times to any unfamiliar vocabulary or other language item contained in the to-be-heard recording so as to facilitate the task. Moreover, modelling strategies that may facilitate the tasks and giving them the opportunity to experience some success in similar tasks through those very strategies may increase their sense of self-efficacy; this will give them greater expectancy of success and a feeling of empowerment which will feed into their sense of competency and control.

Another important implications relate to the way we design the curriculum and assessment. For effective progression from a lower level to a higher one to be possible, students must be given plenty of opportunities to consolidate the material processed at the lower level before moving on. This does not often happen in courses which rely heavily on textbooks. For instance, in most of the institutions I have worked in over 25 years of teaching, I was asked

to teach a unit of work every six-seven weeks, a totally unrealistic pace when contact time is limited to one or two hours a week. The result: the weaker children are usually left behind.

6. **Self-determination theory; Intrinsic and Extrinsic motivation.**

Individuals differ from one another in terms of PLOC (personal locus of causality). Some will feel that their behavior is self-determined; they are the initiators and sustainers of their actions and their PLOC will be internal. Others will see external forces as determinants of their lives; coercing them into actions. These people's PLOC will be external. The internal locus is connected with **intrinsic motivation**, whilst the external locus is connected with **extrinsic** motivation.

Extrinsic motivation is when one is motivated by external factors, such as rewards, social recognition or fear of punishment. This kind of motivation focuses people on rewards rather than action.

Intrinsic motivation, on the other hand, refers to the desire to do things because we enjoy doing them, hence it is a stronger motivator than Extrinsic motivation. Three needs lead to intrinsic motivation:

- Being successful at what we do (i.e. I enjoy French because I am good at it);
- Being connected with others (i.e. I love my French class because I have bonded well with the rest of the class)
- Having autonomy (see below)

An important factor leading to Intrinsic Motivation creation is providing learners with the oppportunity to develop **effectance**. Effectance refers to one of the 3 points made above (being

successful at what we do) and is given rise to when the learner accomplishes success at something that they perceive challenging and falling in what Deci (1997) terms 'Optimal zone of development' – i.e.: a task that it is perceived as difficult enough to be challenging but within the stretch of the learner's ability. Effectance does not arise when we simply give students 'easy' work; that is why the 'easy wins' strategy often fails with students with poor intrinsic motivation; students are not stupid, they know you are dumbing down the work to make them feel good and the ensuing praise will not affect their self-regard as learners of your subject.

Self-determination theory assumes that there are individuals for whom a feeling of being in control of their life and responsible for their actions is very important for their personal fulfillment and, consequently, for their motivation.

Implications of Self-Determination theory for the classroom: it may be useful to identify which students in your classes have an internal or external PLOC. In my experience this is not difficult. Once identified the internal PLOC of the target individuals, it is very important to cater for their self-determination needs and grant them a degree of autonomy in and ownership over their learning. E.g.: when staging a reading session in the classroom; carrying out a project; asking students to practise vocabulary online, let them choose how to go about it (whilst setting some guidelines for the sake of consistency). People with high internal PLOC thrive in self-directed learning tasks and contexts; teachers must endeavour to exploit to the fullest this personality trait's greater potential for autonomy in L2 learning. People with a high external PLOC will need more praise, direction from and a sense of accountability to teachers and caretakers.

Implications of Intrinsic and Extrinsic motivation theory: Pretty obvious. The main ones: (1) make lessons as enjoyable as possible and make them experience EFFECTANCE regularly in your lessons, as this may help boost their intrinsic motivation; (2) Plan every single one of your lessons with the following questions in mind: 'How can I make sure that every student goes out of my lessons feeling they have progressed?; (3) foster connectedness in the class by creating a team spirit and a sense that the whole class is working towards the same goal and that every student feels comfortable working with everyone else (e.g. make sure that people do not work with the same partners all the time when staging group work); give plenty of opportunities for positive peer feedback (e.g. get students' to celebrate other students' achievements). (4) Show them the benefits of learning the TL for their future job prospect, personal growth, etc. and of every activity you stage in lessons in terms of learning benefits; use praise as a means to validate their efforts but ensure that you do not over-praise or it will lose its motivational power (most students can sense when you are just trying to bribe them with compliments; this may engender complacency and even loss of motivation in the long-run).

There is a myth circulating amongst some educators these days (including some of my colleagues) that Extrinsic motivation should not be tapped into as a strategy to encourage students to improve. However, there is no sufficient credible evidence that Extrinsic Motivation is detrimental to learning to do away with it; on the contrary, research shows consistently that extrinsic motivation, when not overused and deployed in synergy with some of the other strategies discussed in this post, can eventually bring about Intrinsic motivation. Example: a student that does not enjoy French may, through experiencing a sense of effectance and obtaining consistent (thoroughly deserved and proportionate) praise and rewards

become more appreciative of the subject, especially if she is experiencing steady growth in her mastery of the language and feels connected and supported by his peers.

It is self-evident that using Extrinsic motivation will work with certain individuals rather than others; hence, as already mentioned, identifying the orientation of their Personal Locus Of Causality (PLOC) is fundamental, prior to carrying out any intervention.

7. **Valence- Instrumentality- Expectancy (VIE) theory**

In this paradigm, motivation refers to three factors

- Valence: what we think we will get out of a given action/behaviour (what's in it for me?)
- Instrumentality: the belief that if I perform a specific course of action I will succeed (clear path?)
- Expectancy: the belief that I will be definitely able to succeed (self-efficacy)

Implications for the classroom:

(1) make clear to students why a specific outcome is desirable (e.g. getting and A/A* at GCSE speaking exams). Make sure you list as many benefits as possible, especially those that most relevant to their personal preferences, interests and life goals;

(2) provide them with a clear path to get there. This may involve showing them a set of strategies they can use (e.g. autonomously seeking opportunities for practice with native speakers in school) or a **clear** course of action they can undertake which is within their grasp (e.g. talk to your teacher about how to improve your essay writing; identify with their help the two or three main issues; work out with them some strategies to address those issues; monitor with

their help through regular feedback and meetings with them that their are working and if they are not why; etc.). A clear path gives a struggling student a sense of empowerment, especially if they feel that they are being provided with effective tips and support to overcome the obstacles in the way;

(3) support their self-belief that that outcome can be achieved (e.g. by mentioning to them examples of students from previous cohorts of similar ability who did it) and by reminding them of similar/comparable challenges they successfully undertook in the past.

8. **Goal-related theory**

In order to direct ourselves in our personal, educational and professional life we set ourselves goals. These can be:

- Clear (so we know what to do and what not to do)
- Challenging (so we get some stimulation)
- Achievable (so we do not fail)

If we set goals ourselves, rather than having them imposed on us, we are more likely to work harder in order to achieve them. Moreover, Locke and Kristoff (1996) identified specific and challenging goals as those which are more likely to lead to higher achievement.

Implications for the classroom: instead of setting goals for your students in a top-down fashion, involve them actively in the process of learning. Moreover, help the students narrow down the goals set as much as possible and gauge them as accurately as possible to their existing level of competence. E.g.: instead of simply telling a student to check his next essay more accurately next time around

and give them a lengthy error checklist, sit down with them and ask them to choose three challenging error categories that they would like to focus on and to aim to attain 80, 90 or even 100% accuracy in those categories in their essay due the following week. Make sure that the knowledge required by the learners to prevent or fix the target errors is learnable and that the students are provided with learning strategies which will assist them in achieving the set goals. I did this in my PhD study with excellent results.

I picked the above theories as they are the ones that I have been using more successfully over 25 years as a classroom teacher and subject leader. It goes without saying that in order to apply them effectively one has to ensure first and foremost that they know and listen to the learners they are dealing with. Cognitive and emotional empathy are a must for the success of any of the above motivational strategies.

These strategies work best in synergy rather than in isolation. In a future post, for instance, I will endeavour to show how attitudinal change may be brought about by using a combination of the above principles to achieve the desired outcomes.

## Factors that may affect students' academic achievement

Here are some of the factors that may affect a student's academic achievement:

- The support and availability of the parents, their financial situation and standard of living. In Québec, as in other places in the world where the topic is studied, it has been observed

that students in socioeconomically disadvantaged areas get lower marks.

- The geographical location of the educational institution.

For example, English as a second language is not learned in the same conditions throughout Québec.

- The percentage of students in a school whose mother tongue is not the language of instruction
- The diversity of student profiles in the same class
- The grouping together, in certain schools, of students with severe learning difficulties, or with problems associated with psychosocial integration in special education classes
- The various practices pertaining to the student admission requirements. Some educational institutions admit students indiscriminately, whereas other select them on the basis of previous academic achievement or their results on aptitude tests.

## Teacher Effectiveness

To make dramatic improvements in all students' preparation for college and careers, states need thoughtful, intentional human capital strategies that get the right teachers in the right places in the right subjects. The need is especially acute in states that have or plan to adopt college- and career-ready academic standards and graduation requirements:

they will need highly effective teachers – particularly in upper-level mathematics and science courses – capable of teaching rigorous

content to all students. State policymakers are well aware that the quality of teaching is the most critical school-based factor contributing to student learning, especially for low-income and minority students.1

The Race to the Top criteria accordingly encourage states to adopt policies to measure the effectiveness of individual teachers and leaders use those measures to inform a range of human capital systems and decisions, ensure an equitable distribution of effective teachers and leaders, and provide high-quality support for educators and principals (see Table 1).

If enacted, all of these policies could help a state advance its college and career readiness agenda, since that agenda will require higher and higher levels of teaching quality in order to succeed. But meeting these criteria presents special challenges in the college and career readiness context, especially when it comes to identifying, developing and deploying effective teachers at the high school level. The challenge is particularly great in high school mathematics and science, where research suggests that subject matter expertise is vital for effective teaching.2

The following two sections focus on those special challenges. The first explores what states need to consider in meeting the Race to the Top's teacher effectiveness criteria at the high school level if they are committed to a college- and career-ready agenda. The second asks how states can go beyond RTTT to provide effective instruction in rigorous content to all students, regardless of where they go to school.

While the Race to the op criteria also encourage states to focus on improving leadership, the focus here is on high school teachers

ecause of the specific issues teacher effectiveness poses for the college- and career-ready agenda.

**Meeting the Race to the Top Challenge:**

Effective High School Teachers Measuring Effectiveness. A central tenet of the Race to the Top criteria is that states need viable approaches to measure the effectiveness of teachers, provide an effectiveness rating to each individual teacher, and use those ratings to inform professional development, compensation, promotion, tenure, and dismissal.

A state's measure must include multiple inputs, but must include "student growth." Even without Race to the Top criteria, experts and education leaders have increasingly come to see current teacher evaluation methods as inadequate, largely because they fail to differentiate between teachers with varying levels of effectiveness.3 Utilizing data about student growth as part of teacher performance measurement presents technical and political challenges even at the elementary and middle school levels, where states increasingly have assessment and data systems that enable year-to-year tracking of individual student progress.4 At the high school level, the challenges are more daunting because, by and large, state assessment systems do not enable this kind of longitudinal tracking of individual student progress from one year to the next. Many states assess high school student mastery through a single cumulative assessment or through a series of end-of-course exams where there is not a clear progression of content from course to course (such as end-of-course exams in Biology and Chemistry). While these assessments may provide valuable information about student achievement, the structure and sequence of states' high school assessment systems may prohibit or make it more challenging to obtain meaningful growth measures.5 A w s

states consider how to meet this RTTT criterion at the high school level, they have several options, each of hich presents significant but not insurmountable challenges to states. These options include:

• Building student-level growth measurement into revised high school assessment systems. Many states will be revising their high school assessment systems as they advance the college- and career- ready agenda and/or compete in the Race to the Top. As they do so, states can design their new systems to measure high school students' progress toward college- and career standards from year to year.

The challenge will be to create a system of assessments with the right sequence and relationship. States pursuing this option would need to design assessments aligned to college- and career-ready end-of-high-school standards, and then design a sequence of assessments taken earlier in high school that share sufficiently related content with the end-of-high-school tests (e.g. end-of-course assessments in Algebra I and Algebra II or English II and English III). School systems would need to report growth results using a metric that allows for meaningful and straightforward interpretations of student progress over time,

which could include approaches using common scales, value tables, or growth percentiles.6 It is also important to note that this option does limit the proportion of teachers within a high school for whom measures of effectiveness could be calculated, since it may not be possible for states to develop an appropriate sequence of related assessments for teachers of all content areas. • Introducing pre-tests or interim assessments aligned to college- and career-ready standards. States with end-of-course or end-of-grade assessments could design beginning-of-the-year pre-tests to assess

students' incoming knowledge, and then generate individual growth scores by comparing pre- and post-test results.

This might seem like an additional burden, but in fact pre-assessment of individual students is likely essential for excellent teaching. States should also consider using interim assessments aligned to college- and career-ready standards and assessments as a method for evaluating individual students' growth towards standards throughout the year.7 Such approaches may allow states to develop measures of teacher effectiveness for content areas in which year-to-year growth measures are not feasible.

## Mapping

. To get the right teachers into the right places in the right subjects, states need a clear picture of the gaps they need to fill. The Race to the Top's premium on improving the distribution of teaching quality to high- poverty schools and hard-to-staff subjects heightens this imperative. The only way to gain this picture is by carefully mapping the quality of teachers currently employed in the state's high schools versus what is needed to meet ambitious college and career readiness goals. Ideally, this mapping would be based on measures of teaching effectiveness rather than on the paper qualifications of teachers, which research suggest are weakly correlated or not correlated with student outcomes.9

Since states typically lack real effectiveness measures at the high school level, however, they will have to rely in the short term on the best available proxies which, in secondary schools, are measures of content knowledge such as teachers' scores on content assessments and teachers' college and graduate school course-taking in the content area(s) they are teaching.

A “map” implies a static picture at a point in time, but states should strive to obtain a dynamic view of the teacher quality distribution. It is important to understand the flows of effective teachers in and out of schools, districts, and the state itself: What kinds of schools are gaining or losing effective teachers over time? Mapping teacher effectiveness would require most states to enhance significantly their data systems. A necessary element is a system of teacher identifiers that enables the state to follow teachers as they move from school to school and reliably link them to the results of the students they are teaching.10

Instituting such a system would also likely require a state to change the reporting it asks districts and schools to do regarding their teacher workforce, to ensure that full data about each teacher’s background and current status are part of the system. In some states, leading districts may already have outpaced the state in developing teacher data systems. In such cases, states have an opportunity to partner with those districts to extend their cutting-edge approaches

## Guidance in schools: Needs, organizational set up and techniques

The guidance refers to advice or information provided by a person of experience, to solve a problem or improve something. The guidance refers to the process of helping individuals to discover and develop their potential. The need of guidance is something that cannot be ignored by anyone. Furthermore, guidance helps in the development of educational, vocational, and psychological skills in an individual. Most noteworthy, guidance would help an individual to achieve an optimal level of happiness and peace in life. Moreover,

an individual who receives proper guidance would surely contribute significantly to society.

The concept of guidance is quite democratic in nature. This is because; a properly guided individual would be able to shape his destiny. Guidance ensures that each individual's choices must serve the interests of the society as well as the interest of the individual.

## Principles of Guidance

The principles of guidance certainly form the basis of the need of guidance. Furthermore, principles of guidance are important principles without which guidance cannot take place. Below are the principles of guidance:

Principle of all-round development- Guidance must take into account the all-round development of the person. Furthermore, guidance must ensure this desirable adjustment in any specific area of the individual' personality.
Principle of human uniqueness- Certainly no two individuals are alike. Furthermore, individuals differ in mental, social, physical, and emotional development. Moreover, guidance must recognise these important differences and guide individuals according to their specific need.

Principle of holistic development- This principle states that guidance must take place in the context of total personality development. Moreover, a child grows as a whole. Also, if one aspect of personality is in focus, then the other areas of development must be kept in mind. Most noteworthy, these other areas of development indirectly influence the personality.

Principle of cooperation- This principle states that there cannot be any force on any individual regarding guidance. Moreover, the cooperation and consent of the individual is a pre-requisite for providing guidance.

Principle of continuity- The principle says that the guidance must take place as a continuous process to an individual. Also, this guidance must take place in different stages of the individual's life.

Principle of extension- In this principle, there should not be a limitation of guidance to a few individuals. Most noteworthy, the extension of guidance must be to all individuals of all ages.

Principle of adjustment- It is certainly true that guidance influences every aspect of an individual's life. However, guidance is chiefly concerned with a person's mental or physical health. Furthermore, this adjustment takes place at school, home, society, and vocation.

## Need of Guidance

Guidance certainly has an enormous need in every individual's life. Below are some factors which highlight the need for guidance:

Different stages of development- The division of an individual's life can take place into various stages. These stages are infant, childhood, pre-adolescent, adolescence and manhood. So, an individual needs guidance in every stage of life. Maximum guidance is required during the adolescence stage.

Differences among persons- Psychology inform us that no individuals are alike. Furthermore, no two individuals get similar opportunities in life. Therefore, every individual requires guidance, in order to find out the most suitable profession for him.

Career Maturity- Guidance is certainly essential for the development of a positive work attitude. Furthermore, guidance would help build suitable habits and values towards one's work or profession. This is because; guidance increases the awareness of one's world of work. Also, an individual is able to plan and prepare for his work or profession efficiently due to guidance.

Educational growth- Guidance certainly helps in the development of educational skills and abilities. Above all, these skills would facilitate learning and achievement.

## WHY SHOULD YOU DEVELOP A STRUCTURE FOR YOUR ORGANIZATION?

- **Structure gives members clear guidelines for how to proceed.** A clearly-established structure gives the group a means to maintain order and resolve disagreements.

- **Structure binds members together.** It gives meaning and identity to the people who join the group, as well as to the group itself.
- **Structure in any organization is inevitable** -- an organization, *by definition*, implies a structure. Your group is going to have some structure whether it chooses to or not. It might as well be the structure which best matches up with what kind of organization you have, what kind of people are in it, and what you see yourself doing.

## WHEN SHOULD YOU DEVELOP A STRUCTURE FOR YOUR ORGANIZATION?

It is important to deal with structure early in the organization's development. Structural development can occur *in proportion* to other work the organization is doing, so that it does not crowd out that work. And it can occur *in parallel* with, at the same time as, your organization's growing accomplishments, so they take place in tandem, side by side. This means that you should think about structure from the beginning of your organization's life. As your group grows and changes, so should your thinking on the group's structure.

## ELEMENTS OF STRUCTURE

While the need for structure is clear, the best structure for a particular coalition is harder to determine. The best structure for any organization will depend upon who its members are, what the setting is, and how far the organization has come in its development.

Regardless of what type of structure your organization decides upon, three elements will always be there. They are inherent in the very idea of an organizational structure.

They are:

- Some kind of governance
- Rules by which the organization operates
- A distribution of work

## Governance

The first element of structure is governance - some person or group has to make the decisions within the organization.

## Rules by which the organization operates

Another important part of structure is having rules by which the organization operates. Many of these rules may be explicitly stated, while others may be implicit and unstated, though not necessarily any less powerful.

## Distribution of work

Inherent in any organizational structure also is a distribution of work. The distribution can be formal or informal, temporary or enduring, but every organization will have some type of division of labor.

There are four tasks that are key to any group:

- *Envisioning desired changes*. The group needs someone who looks at the world in a slightly different way and believes he or she can make others look at things from the same point of view.

- *Transforming the community*. The group needs people who will go out and do the work that has been envisioned.
- *Planning for integration*. Someone needs to take the vision and figure out how to accomplish it by breaking it up into strategies and goals.
- *Supporting the efforts of those working to promote change*. The group needs support from the community to raise money for the organization, champion the initiative in the state legislature, and ensure that they continue working towards their vision.

## COMMON ROLES

Every group is different, and so each will have slightly different terms for the roles individuals play in their organization, but below are some common terms, along with definitions and their typical functions.

- An initial *steering committee* is the group of people who get things started. Often, this group will create plans for funding, and organizational and board development. It may also generate by-laws, and then dissolve. If they continue to meet after approximately the first six months, we might say they have metamorphosed into a *coordinating council*.
- A *coordinating council* (also referred to as a *coordinating committee, executive committee*, and *executive council*), modifies broad, organization-wide objectives and strategies in response to input from individuals or committees.
- Often, one person will take the place of the coordinating council, or may serve as its head. Such a person may be known as the *Executive Director, Project Coordinator, Program*

*Director,* or *President*. He or she sometimes has a paid position, and may coordinate, manage, inspire, supervise, and support the work of other members of the organization.

- *Task forces* are made up of members who work together around broad objectives. Task forces integrate the ideas set forward with the community work being done.

For example, from the director of a coalition to reduce violence in a medium-sized city: "Currently, we have three operational task forces. Members of each have an ongoing dialogue with members of the coordinating council, and also with their action committees. The oldest was formed with the goal of eliminating domestic violence about fifteen years ago, when a local woman was killed by her husband. Then, after several outbreaks of violence in the schools a few years back, our group offered to help, and a second task force sprung up around reducing youth violence. We've just started a third, with the goal of increasing gun safety.

"All of it is interrelated, and all of it applies to our mission of increasing the safety of residents of South Haven, as well as that of our visitors. But each task force is contributing to that mission in vastly different ways, with different objectives, and using different strategies. 'Cause, you know, the strategies you use to stop a ninth grader from bringing a gun to school just aren't the same as the ones you use to stop a 40-year-old man on unemployment from beating his wife."

- *Action committees* bring about specific changes in programs, policies, and practices in the sectors in which they work.

For example, the task force on domestic violence mentioned above has the following action committees:

- *A government and law enforcement committee*. Members include police officers, lawyers, a judge, and a state representative. Currently, they are trying to pass laws with stronger penalties for those convicted of domestic violence, especially repeat offenders. They are also training officers to be better able to spot an abusive relationship, and better able to inform a victim of his or her options.
- *A social services committee*. Members (who include representatives from most of the service agencies in town) work to assure that staff members know where to send someone for the resources he or she needs. They are also trying to increase the number of trained volunteer counselors who work at the battered women's shelter.
- *A media committee*. Members include local journalists, writers, and graphic designers. They keep the project and the issue in the public's minds as much as possible with editorials, articles and news clips of events, as well as advertisements and public service announcements.
- *Support committees* are groups that help ensure that action committees or other individuals will have the resources and opportunities necessary to realize their vision. Financial and media committees are examples of committees formed to help support or facilitate your work.
- *Community trustees*, also known as the board of trustees or as the *board of directors*, provide overall support, advice, and resources to members of the action groups. They are often either people who are directly affected by the issue or have stature in the community. That way, they are able to make contacts, network with other community leaders, and generally

remove or weaken barriers to meeting organizational objectives.

- *Grantmakers* are another part of the picture. Grantmakers exist on an international, national, state, and local level and may be private companies and foundations, or local, county, state, or federal government organizations (for example, block grants given by the city would fall into this category).
- *Support organizations* (not to be confused with the *support committees* listed above) are groups that can give your organization the technical assistance it needs.
- *Partner organizations* are other groups working on some of the same issues as your organization.

Although this list is pretty extensive, your organization may only use two or three of the above mentioned roles, especially at the beginning. It's not uncommon for a group to start with a steering committee, ask others to serve as board members, and then recruit volunteers who will serve as members of action committees. In this broad spectrum of possibilities, consider: Where does your organization fit in? Where do you want to be?

EXAMPLES OF STRUCTURE

So how can all of these pieces be put together? Again, the form a community group takes should be based on what it *does*, and not the other way around. The structures given are simply meant to serve as examples that have been found to be effective for some community-based organizations; they can and should be adapted and modified for your own group's purposes.

A RELATIVELY COMPLEX STRUCTURE

## Example - The Ste. Genevieve's Children's Coalition

The Ste. Genevieve's Children's Coalition is a relatively large community-based group. They have a coordinating council, a media committee, and three task forces, dealing with adolescent pregnancy, immunization, and child hunger. Each of the task forces has action committees as well. For example, the adolescent pregnancy reduction task force has a schools committee that focuses on keeping teen parents in school and modifying the human sexuality curriculum. A health organizations committee focuses on increasing access and use of the youth clinic. The media committee works to keep children's issues in the news, and includes professionals from the local television stations, radio stations, newspaper, and a marketing professional. The coordinating council is composed of the executive director, her assistant, the media committee chair, and the chairs of each of the three task forces. A board of directors has been invaluable in helping keep the coalition financially viable.

## Counselling: Process, skills, and techniques

(ACA), professional counseling is the process of building relationships with individuals that empower them to accomplish mental health and wellness, education, and career goals. It is a collaborative relationship between the counselor and their client.

Professional counseling can take the form of:

- *Individual counseling* is the most common type of counseling that focuses on the growth and mental health of an individual.

- *Couples or marriage counseling* focuses on assisting couples in overcoming conflict and working towards a stronger relationship.
- *Family counseling* involves the different familial dynamics and how they affect the family structure.
- *Group counseling* is the use of group interaction to facilitate growth.

When you become a counselor, you are likely to engage in many of these types of counseling throughout your therapeutic work.

The Process of Counseling

following components.

**Opening**: The opening process is perhaps, one of the most important parts of the interaction with your client. It is your chance to get to know your client and for them to get to know you. It is also where you will set the tone for the rest of the therapeutic relationship.

**Exploring Client Understanding:** The exploration process is where you will begin to understand your client. You will explore their past and evaluate their current concerns. Here, you will together establish goals and set expectations.

**Understanding:** Important in developing a strong relationship with your client, you can demonstrate understanding by using verbal and nonverbal cues, as well as reflections and paraphrases.

**Intervention:** The intervention process is about choosing the appropriate counseling techniques that will encourage growth within your client.

**Exploring Problems:** Exploration is the process of learning more about your client and why they have come to counseling. Exploration is necessary in truly understanding a client's thoughts and feelings in relation to their pressing problem.

**Empower to Create Own Solutions:** Empowering your client is not about providing them with all the answers. It is about empowering them, with your counseling skills, to find their own solutions.

Counseling Skills

As a student, your master's degree in counseling is about developing and expanding upon the counseling skills that will best help your clients. These are some of the most important counseling techniques you are likely to use in your counseling sessions.

***Listening/Observing***: Listening is one of the most valuable counseling skills in the therapeutic relationship. It can be used in three ways:

- *Attending*: Attending is the ability to be physically present for the client. It means giving them your undivided attention and making appropriate eye contact, mirroring body language, and nodding. These attending behaviors show your client that you care. In fact
- *Active listening*: Active listening occurs when you are listening with all of your senses. According to the , active listening involves listening with your body, heart, ears, eyes, and mouth.
- *Verbal listening*: This is a form of showing you are listening through the words that you use.. This can be as simple as 'yes', or 'go on'. It can also be in the form of paraphrasing or repeating a word of emotion that the client has just said.

***Asking Questions***: Questions are helpful in the therapeutic environment because they allow you to learn more about your client. The type of questions that you ask will set the tone of the session and the entire counseling process. Questions occur in two forms.

- *Closed*: A closed question is the practice of asking a question that can be answered as a 'yes' or 'no'. Closed questions should generally be avoided in the counseling relationship, as they do not encourage deeper exploration.
- *Open*: An open question is necessary to gather information. An open question is one that cannot be answered with a simple 'yes' or 'no' and it requires reflection or exploration on the client's end. Every open question should be intentional and therapeutic.
- *Feelings reflections*: Reflections allow clients to hear the feelings they have just expressed. Sometimes you have to look for the descriptive feeling in a client's statement. It can also be helpful to look at a client's nonverbal feeling cues.
- *Restating/Rephrasing*: Restating and rephrasing can build a stronger client therapist relationship. Rephrasing a client's statement allows you to better understand what a client has just said and to gain further clarity, if you have gotten it wrong.
- *Affirmation*: Affirmation is a form of encouragement that is used to affirm behaviors or life choices. Affirmation is important for empowering clients External link . A few common affirmations include affirming progress that a client has made toward a goal or encouraging a client to do what is important to them.

***Empathy***: Empathy is the ability to put yourself in someone else's shoes. It is much more than sympathy in that you are able to show your understanding of your clients feeling surrounding an experience.

***Genuineness***: Begin genuine is creating congruence between yourself and your words. Every therapist is different and will provide a different therapeutic process. It is important to remain genuine in all counseling techniques and verbal and nonverbal cues.

***Unconditional Positive Regard***: Demonstrating unconditional positive regard External link is the idea of accepting your client for who they are. It is a means of expressing warmth and respect.

***Counselor Self-Disclosure***: This is a tricky counseling skill to maneuver. A general rule to follow is to only share personal information that is beneficial to the therapeutic process. It might also be used to help the counselor relate better with their client.

Counseling Theories

Counseling theories External link are used as a guideline for understanding human nature and to determine which counseling skills you will use in your counseling sessions.

- ***Psychoanalytic Theory***: This theory was originally developed by Sigmund Freud. It supports the idea that unconscious forces drive human actions. A psychoanalytic therapy session includes skills such as dream analysis, free association, resistance analysis, and transference analysis. Much of the personality is thought to have developed in childhood and similarities are identified and explored in the therapeutic relationship.

- ***Person-Centered Therapy***: This theory is a form of psychotherapy originally developed by Carl Rogers. Sometimes also known as Rogerian therapy, it operates on the assumption that every human being has the ability to fulfil their full potential. A client-centered approach in the therapeutic relationship involves self-actualization, empathy, and unconditional positive regard. When practicing person-centered therapy, the client therapist relationship is very important because the positive interactions are a form of therapy themselves. The relationship should be supportive and the therapist acts more as a guide, as the client is the expert of their own life.
- ***Cognitive Behavioral Therapy (CBT)***: CBT is a shorter term approach External link to the therapeutic process. This hands-on approach lends its practice to the theory that human problems stem from faulty patterns of thinking. The counseling process primarily involves the challenge of automatic thinking and often negative thought patterns. It encourages the client to find logic in their way of thinking. The counselor plays an important role in challenging these thoughts.
- ***The Family Systems Model***: Family Systems view all human troubles and conflicts as a familial unit. The theory, originally developed by Murray Bowen, is focused on the idea that family is the primary source of emotions and personality. A family system can be present in many forms, including structural, strategic, and intergenerational. Common techniques used in the therapeutic process include the creation of a genogram, family projection activities, emotional triangles, and the differentiation of self. This counseling theory is often used in marriage and family counseling sessions.

Counseling is about creating strong relationships with your clients that will empower them to obtain mental health and to fulfill their goals. Through the use of intentional counseling techniques and an understanding of human nature developed through counseling theories, you can guide your client in reaching optimal mental health.

Effective Counselling Skills

Counsellors use counselling skills to help them better understand and listen to clients.

Through **active listening**, rapport is built, trust forms and the speaker feels heard and understood by the counsellor or listener.

Core Counselling Skills

Core listening skills are basic counselling skills, or practiced techniques, that help the counsellor to empathetically listen to the speaker.

Skills include:

- active listening
- being aware of nonverbal communication
- building rapport

The core counselling skills are described below.

1. Attending

Attending in counselling means being in the company of someone else and **giving that person your full attention**, to what they are saying or doing, valuing them as worthy individuals.

2. Silence

Silence in counselling gives the client control of the content, pace and objectives.

This includes the counsellor *listening to silences as well as words*, sitting with them and recognising that the silences may facilitate the counselling process.

3. Reflecting and Paraphrasing

Reflecting in counselling is part of the ‘art of listening’. It is making sure that the client knows their story is being listened to.

This is achieved by the helper/counsellor by both **repeating and feeding a shorter version of their story back to the client**. This known as '**paraphrasing**'.

4. Clarifying and the Use of Questions

Questions in counselling are classed as a basic skill. The counsellor uses open questions to clarify his or her understanding of what the client is feeling.

**Leading questions are to be avoided** as they can impair the counselling relationship.

5. Focusing

Focusing in counselling involves making decisions about what issues the client wants to deal with.

The client may have mentioned a range of issues and problems and focusing allows the counsellor and client together to clear away some of the less important surrounding material and **concentrate on the central issues** of concern.

6. Building Rapport

Building rapport with clients in counselling is important, whatever model of counselling the counsellor is working with.

Rapport means **a sense of having a connection with the person**.

7. Summarising

Summaries in counselling are longer paraphrases. They **condense or crystallise the essence of what the client is saying and feeling**.

The summary 'sums up' the main themes that are emerging.

8. Immediacy

Using immediacy means that the therapist reveals how they themselves are feeling in response to the client.

According to Feltham and Dryden (1993: 88), immediacy is 'the key skill of focusing attention on the here and now relationship of counsellor and client with helpful timing, in order to challenge defensiveness and/or heighten awareness'.

Counseling Skills and Techniques

Types of Counseling and Techniques

Counselors must possess in-depth knowledge and skills if they are to help clients effectively. On the job, these professionals use a specific set of counseling skills to treat one or more unique populations. These counseling techniques may vary depending on which group of people a counselor serves (e.g., Counseling techniques appropriate for school counselors may not work for grief counselors.). In a master's program, counselors-in-training hone skills through practica and supervised work experience.

How Do Different Mental Health Professions' Skills Stack Up?

All mental health professionals possess similar skills. In graduate-level counseling programs, all counselors-in-training first master a standard skill set. Only after specializing in a particular counseling subfield (e.g., addiction counseling, school counseling, etc.) do they begin to explore new skills that can help their future clients.

Counselor vs Therapist Skills

On the job, counselors and therapists share many similar duties. Also, professionals in both careers typically possess master's degrees. However, therapists (e.g., marriage and family therapists) have a more honed skill set when it comes to interpreting clinical research. Also, unlike counselors, therapists play a more significant role in helping clients develop solutions to problems.

Counselor vs Psychologist Skills

Although some psychologists possess a master's degree, many earn a doctorate, especially if they plan to teach psychology at the college level. On the job, they review the latest research to find new ways to treat clients, a task few counselors undertake. Psychologists also possess honed research and analytical skills, a boon if they plan to contribute original research to the psychology field.

Counselor vs Psychiatrist Skills

Psychiatrists possess the most advanced skill set of all mental health professionals. They first earn a medical degree before completing a residency in psychiatry. In addition to applying the interpersonal skills that psychologists and counselors possess, they use their pharmacological knowledge to prescribe medication when necessary. .

Counselor vs Social Worker Skills

Although social workers and counselors help clients in similar ways, social workers must have the collaborative and interpersonal skills necessary to research and provide community resources. For example, a school social worker who believes that a child lives in an unsafe environment must coordinate with law enforcement and child protective services, among other relevant government agencies.

5 Skills Every Counselor Should Possess

1

**Communication Skills:** An excellent counselor can convey information in a concise way that ensures that a client understands the counselor's concerns, advice, etc. This way, a client can leave a session without feeling confused and assured that the counselor answered all of his or her questions.

2

**Listening and Attending:** Counselors need more than excellent listening and comprehension skills. During a session with a client, counselors must also project that they have a vested and genuine interest in the client's well being. They do this by making eye contact and using appropriate body language - counseling skills and techniques that also apply to the psychiatry and therapy fields.

3

**Focusing and Paraphrasing:** When a client first meets with a counselor, he or she may not know their problems' root cause(s). The counselor must identify the client's issues and help the client decide which are causing the most harm. This way, the counselor and client can focus on those issues and develop solutions.

4

**Validating and Challenging:** As counselors provide mental health services, they must make clients feel validated - that it is normal to feel upset, nervous, angry, etc. However, counselors must also challenge clients to adopt actions or mindsets that go against these feelings, ones that clients may not want to give up. Effective challenging requires excellent interpersonal and diplomatic skills.

5

**Multicultural Competencies:** Counselors, especially guidance and school counselors, must possess multicultural competencies. In other words, a counselor should understand how a client's racial, cultural, and socioeconomic background affects them. Counselors can use this knowledge to better empathize with clients, gain their trust, and develop effective solutions.

## Mental Health Counseling Techniques

To make counseling effective, counselors must not only master counseling skills and techniques but also understand the different theories that guide mental health professionals. Comprehensive online master's in mental health counseling programs typically emphasize the following four theories - their history, impact, and continued relevance.

## 1. Behavioral Theory

Behavioral theory explains people's behavior by examining life experiences. Psychologist B.F. Skinner was an advocate for behavioral theory, as he showed through animal testing that conditioning could affect behavior significantly. In a modern context, a behaviorist might argue that someone possesses violent tendencies because that person suffered physical abuse as a child.

## 2. Cognitive Theory

Instead of focusing on actions, cognitive theory examines how people's thoughts influence their behavior. In a clinical setting, psychologists and psychiatrists use talk therapy to help clients identify and remedy negative thoughts. For example, a client who can verbalize his or her flying anxiety can begin to develop new, positive thought patterns that reduce stress.

### 3. Humanistic Theory

After the Second World War, many mental health professionals turned away from traditional behavioral and cognitive theories. Humanistic theory assumes that people are good and desire agency over their own lives. Counselors who use humanistic theory focus on clients' subjective feelings and use those feelings as a way to treat underlying problems.

### 4. Integrative Theory

As the name suggests, integrative theory synthesizes behavioral, cognitive, and humanistic theories, among others. Professionals who use integrative theory analyze clients' mental health needs from different viewpoints and also consider how age and life experience can guide treatment. Finally, integrative theory focuses less on finding a mental health 'cure.' Rather, professionals help clients improve as much as they can.

## School Counseling Techniques

School counselors possess a variety of techniques/skills that allow them to help students, collaborate with faculty, and implement new district- and school-level policies. In online master's in school counseling programs, students begin developing these skills before honing them in school settings (e.g, a practicum). However, many

professionals do not master these skills until after they have acquired significant on-the-job experience.

### 1. Problem-Solving and Conflict Resolution

Without much life experience to pull from, primary and secondary school students lack developed problem-solving and conflict resolution skills (e.g., dealing with a bully, student-teacher conflict, etc.). As a result, counselors must help students identify and remedy problem behavior. When more than one student is involved, counselors use small-group counseling techniques.

### 2. Group Counseling Theories

Group counseling has many advantages in the school setting. One, it brings together students who may share a similar problem or were part of a conflict. Group counseling can also promote empathy among students. Finally, group counseling allows a counselor to help many students at once, freeing up more time for other responsibilities and tasks.

### 3. Special Needs Counseling

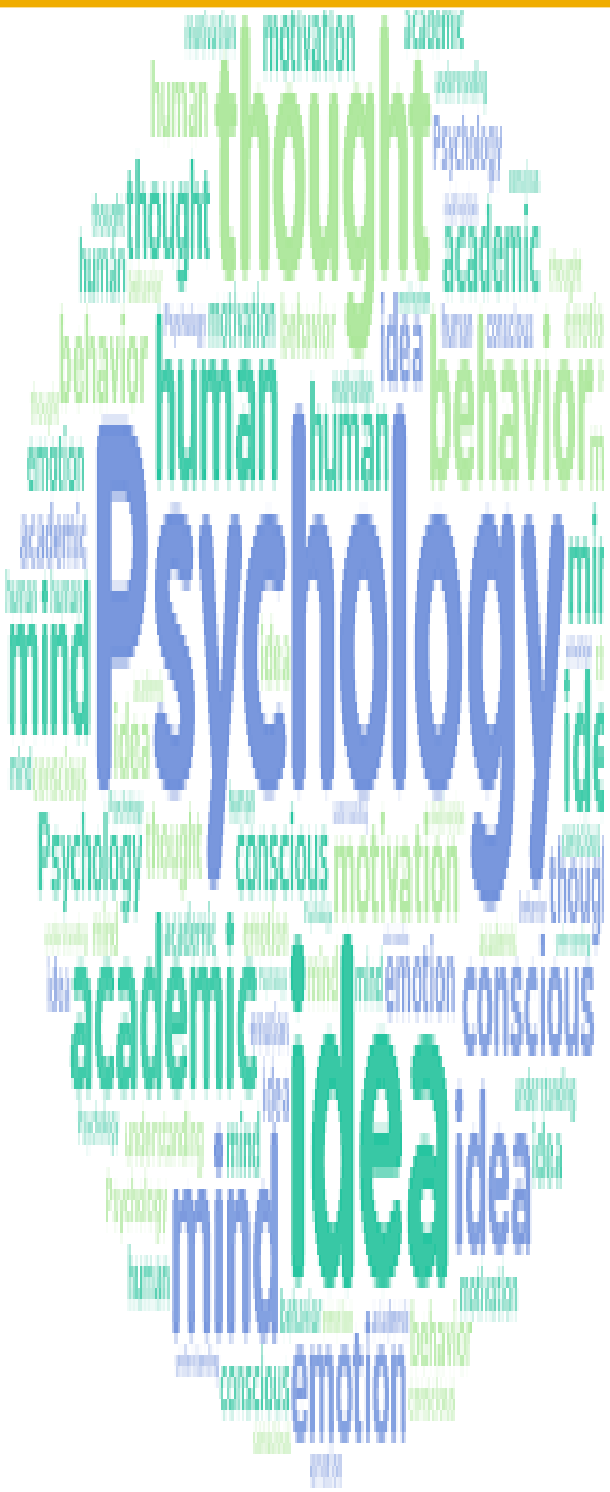
Students with special needs (e.g., ADD, ADHD, Autism-spectrum disorder, etc.) require highly trained counselors who can promote their academic success while working within the context of the disability. Counselors-in-training must examine the latest research and work with students with disabilities. On the job, counselors collaborate with parents, administrators, and faculty to ensure that students with disabilities receive the best education possible.

## Impact of Effective Counseling Techniques

Effective counseling can make a significant, positive impact on clients' lives. Some positive outcomes might include:

- Better decision making
- Coping skills
- Improved outlook on life
- Ability to plan for the future (e.g., college and career preparedness)
- Improve socialization with peers, teachers, and family
- Engagement with extracurricular activities

# UNIT-9 Human Development and Interventions MCQs

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**1. In Operant conditioning procedure, the role of reinforcement is:**
**(a) Strikingly significant**
**(b) Very insignificant**
**(c) Negligible**
**(d) Not necessary**
**(e) None of the above**

**Answer: A**

**2. According to Skinnerian Operant conditioning theory, a negative reinforcement is:**
**(a) Nothing but punishment**
**(b) A biofeedback**
**(c) A withdrawing or removal of a positive reinforcer**
**(d) An instinctive drift**
**(e) None of the above**
**Answer: C**

**3. Behaviour therapists believe that the respondent or classical conditioning is effective in dealing with the non-voluntary automatic behaviour, whereas the operant one is successful predominantly with motor and cognitive behaviours, Thus, unadaptive habits such as nail biting, trichotillomania, enuresis encopresis, thumb sucking etc. are satisfactorily dealt within the :**
**(a) Classical Method**
**(b) Operant Method**
**(c) Trial and Error Method**
**(d) Insightful learning procedure**
**(e) None of the above**
**Answer: B**

**4. Current positive reinforcement requires the individual to imagine performing a particular task or behaviour followed by a:**
**(a) Negative consequence**
**(b) Zero consequence**
**(c) Positive Consequence**
**(d) Neutral consequence**
**(e) None of the above**
**Answer: C**

**5. Aversion is one of the conditioning procedures used in:**
**(a) Non-directive therapy**
**(b) Psychoanalytic therapy**
**(c) Behaviour therapy**
**(d) Chemotherapy**
**(e) None of the above**
**Answer: C**

**6. A very useful principle of learning is that a new response is strengthened by:**
**(a) Punishment**
**(b) Reinforcement**
**(c) Biofeedback**

**(d) Discriminative Stimulus**
**(e) None of the above**
**Answer: B**

**7. In continuous reinforcement schedule (CRF), every appropriate response:**
**(a) Is reinforced**
**(b) Is not reinforced**
**(c) Is sometimes reinforced**
**(d) Is an instinctive drift**
**(e) None of the above**
**Answer: A**

**8. The continuous reinforcement schedule is generally used:**
**(a) In the last part of training**
**(b) In early stages of training**
**(c) In the middle period of training**
**(d) In both last and first part of training**
**(e) None of the above**
**Answer: B**

**9. In real life, reinforcement of every response (CRF) is:**
**(a) Of the nature of an exception rather than the rule**
**(b) Impossible**
**(c) Necessary**
**(d) Not necessary**
**(e) None of the above**
**Answer: A**

**10. Which schedule of reinforcement is a ratio schedule stating a ratio of responses to reinforcements?**
**(a) Variable Ratio Schedule**
**(b) Fixed Interval Schedule**
**(c) Variable Interval Schedule**
**(d) Fixed Ratio Schedule**
**(e) None of the above**
**Answer: D**

**11. Respondents are elicited and operants are not elicited but they are:**
**(a) Emitted spontaneously**
**(b) Emitted voluntarily**
**(c) Permanent responses**
**(d) Temporary responses**
**(e) None of the above**
**Answer: A**

**12. In which schedule of reinforcement, appropriate movements are reinforced after varying number of responses?**
**(a) Fixed Ratio Schedule**
**(b) Fixed Interval Schedule**
**(c) Variable ratio Schedule**
**(d) Variable Interval Schedule**
**(e) None of the above**
**Answer: C**

**13. Which schedule of reinforcement does not specify any fixed number, rather states the requirement in terms of an average?**
**(a) Variable Ratio Schedule**
**(b) Fixed Ratio Schedule**
**(c) Fixed Interval Schedule**
**(d) Variable Interval Schedule**
**(e) None of the above**
**Answer: A**

**14. As a rule, variable ratio schedule (VR) arrangements sustain:**
**(a) Low rates of responding**
**(b) High rates of responding**
**(c) Zero responding**
**(d) 90% of responding**
**(e) None of the above**
**Answer: B**

**15. Under conditions of variable ratio schedule, the only sensible way to obtain more reinforcements is through emitting:**
**(a) 50% responses**
**(b) 90% responses**
**(c) Less number of responses**
**(d) Greater number of responses**
**(e) None of the above**
**Answer: D**

**16. In which schedule of reinforcement, the experimenter (E) reinforces the first correct response after a given length of dine?**
**(a) Fixed Ratio Schedule**
**(b) Fixed Interval Schedule**
**(c) Variable Ratio Schedule**
**(d) Variable Interval Schedule**
**(e) None of the above**
**Answer: B**

**17. In our daily life, watching for the pot of milk to boil may be somewhat similar to the behaviour pattern observed in:**
**(a) Fixed Interval Schedule**
**(b) Fixed Ratio Schedule**
**(c) Variable Ratio Schedule**
**(d) Variable Interval Schedule**
**(e) None of the above**
**Answer: A**

**18. In which schedule of reinforcement, the delay intervals vary as per a previously decided plan?**
**(a) Fixed Ratio Schedule**
**(b) Variable Ratio Schedule**
**(c) Fixed Interval Schedule**
**(d) Variable Interval Schedule**
**(e) None of the above**
**Answer: D**

**19. In our daily life, any kind of looking for things which occur**

**without any reference to our behaviour may illustrate the application of:**
**(a) Variable Interval Schedule**
**(b) Fixed Ratio**
**(c) Variable Ratio Schedule**
**(d) Fixed interval Schedule**
**(e) None of the above**
**Answer: A**

**20. In case of continuous reinforcement, we get the least resistance to extinction and the:**
**(a) Highest response rate during training**
**(b) 50% response rate during training**
**(c) Smallest response rate during training**
**(d) 90% response rate during training**
**(e) None of the above**
**Answer: C**

**21. The expression "Contingencies of reinforcement" occurs frequently in:**
**(a) Operant Conditioning Literature**
**(b) Classical Conditioning Literature**
**(c) Trial and Error Learning Literature**
**(d) Latent Learning Literature**
**(e) None of the above**
**Answer: C**

**22. Who illucidates the contiguity theory of reinforcement in the most pronounced and consistent manner?**
**(a) C. Hull**
**(b) Guthrie**
**(c) Tolman**
**(d) Mc Dougall**
**(e) J. B. Watson**
**Answer: B**

**23. In comparison with drive-reduction or need- reduction interpretation, stimulus intensity reduction theory has an added advantage in that:**
**(a) It offers a unified account of primary and learned drives as also of primary and conditioned reinforcement**
**(c) It has some mathematical derivations which are conducive for learning theorists**
**(d) All learning theories can be explained through this**
**(e) None of the above**
**Answer: A**

**24. Who preferred to call Classical Conditioning" by the name of "Sign Learning"?**
**(a) I. P. Pavlov**
**(b) Mowrer**
**(c) Miller**

**(d) Guthrie**
**(e) J. B. Watson**
**Answer: B**

**25. Which type of learning tells us what to do with the world and applies to what is commonly called habit formation?**
**(a) Insightful Learning**
**(b) Latent Learning**
**(c) Trial and Error Learning**
**(d) Instrumental Learning**
**(e) Classical Conditioning**
**Answer: D**

**26. Who propounded the expectancy theory of learning?**
**(a) Guthrie**
**(b) C. Hull**
**(c) Tolman**
**(d) Thorndike**
**(e) I. P. Pavlov**
**Answer: C**

**27. Who said that any act is a movement but not vice versa?**
**(a) J.B. Watson**
**(b) W. Kohler**
**(c) Guthrie**
**(d) E. L. Thorndike**
**(e) C. Hull**
**Answer: C**

**28. Guthrie believed that conditioning should take place:**
**(a) After two trials**
**(b) After three trials**
**(c) After a single trial**
**(d) After ten trials**
**(e) None of the above**
**Answer: C**

**29. According to Guthrie, forgetting is not a matter of decay of old impressions and associations but:**
**(a) A result of inhibition of old connections by new ones**
**(b) A result of disinhibitions of old connections**
**(c) A result of generalizations of stimuli**
**(d) A result of discrimination**
**(e) None of the above**
**Answer: A**

**30. The great learning theorist, Clark Hull was influenced by the moderate wing of:**
**(a) Gestalt Psychology**
**(b) Behaviouristic Orientation**
**(c) Psychoanalytic Literature**
**(d) Logical Positivism and by conven-tionalism**
**(e) None of the above**
**Answer: D**

**31. Who defined "Need" as a state of the organism in which a deviation of the organism from the optimum of biological conditions necessary for survival takes place?**
**(a) Mc Dougall**
**(b) Clark H. Hull**
**(c) E.L Thorndike**
**(d) I.P. Pavlov**
**(e) None of the above**
**Answer: B**

**32. According to Hullian theory, under the pressure of needs and drives, the organism undertakes:**
**(a) Adaptive actions**
**(b) Learning by foresight**
**(c) Learning by hindsight**
**(d) Transfer of training**
**(e) None of the above**
**Answer: A**

**33. Hull believes that no conditioning will take place unless there is:**
**(a) Food**
**(b) Need Reduction**
**(c) Puzzle Box**
**(d) Secondary Reinforcement**
**(e) None of the above**
**Answer: B**

**34. Who defined stimulus (S) in terms of physical energy such as mechanical pressure, sound, light etc.?**
**(a) E. L. Thorndike**
**(b) W. Kohler**
**(c) B. F. Skinner**
**(d) Clark Hull**
**(e) E. C. Tolman**
**Answer: D**

**35. "Where a reaction (R) takes place in temporal contiguity with an afferent receptor impulse (S) resulting from the impact upon a receptor of a stimulus energy (S) and the conjunction is followed closely by the diminution in a need and the associated diminution in the drive, D, and in the drive receptor discharge, $S_D$, there will result in increment, A (S →R), in the tendency for that stimulus on subsequent occasions to evoke that reaction". Who has given the above definition of "reinforcement"?**
**(a) Clark L. Hull**
**(b) E. L. Thorndike**
**(c) I.P. Pavlov**
**(d) W. Kohler**
**(e) None of the above**
**Answer: A**

**36. Most of Hull's explanations are stated in two languages, one of the empirical description and the other in:**
**(a) Psycho physiological terms**
**(b) Neurophysiological terms**
**(c) Physiological terms**
**(c) Physical terms**
**(e) None of the above**
**Answer: B**

**37. The molar approach deals with the organism as a whole, the molecular approach:**
**(a) Deals with parts**
**(b) Deals with stimuli**
**(c) Deals with responses**
**(d) Has nothing to do with the organism**
**(e) Deals with the detailed, fine and exact elements of action of the nervous system**
**Answer: E**

**38. The hypothetico-deductive system in geometry was developed by:**
**(a) I.P. Pavlov**
**(b) B. L. Thorndike**
**(c) C. Hull**
**(d) Pieri**
**(e) E. C. Tolman**
**Answer: D**

**39. Whenever behaviour is correlated to specific eliciting stimuli, it is:**
**(a) Respondent Behaviour**
**(b) Operant Behaviour**
**(c) Stimulant Behaviour**
**(d) Fixed Behaviour**
**(e) Static Behaviour**
**Answer: A**

**40. Whenever behaviour is not correlated to any specific eliciting stimuli, it is:**
**(a) Respondent Behaviour**
**(b) Operant Behaviour**
**(c) Static Behaviour**
**(d) Modified Behaviour**
**(e) None of the above**
**Answer: B**

**41. According to Tolman, docile or teachable behaviour is:**
**(a) Molar**
**(b) Molecular**
**(c) Respondent**
**(d) Operant**
**(e) None of the above**
**Answer: A**

**42. According to Skinnerian theory, the "S" type of conditioning applies to:**

**(a) Modified Behaviour**
**(b) Stimulant Behaviour**
**(c) Operant Behaviour**
**(d) Respondent Behaviour**
**(e) None of the above**
**Answer: D**

**43. The sign-gestalt expectation represents a combination of:**
**(a) Intelligence and Perception**
**(b) Perception and Learning**
**(c) Intelligence and Learning**
**(d) Perception and Motivation**
**(e) None of the above**
**Answer: D**

**44. Who stated that appetites and aversions are "states of agitation"?**
**(a) E. L. Thorndike**
**(b) E. C. Tolman**
**(c) W. Kohler**
**(d) Clark Hull**
**(e) None of the above**
**Answer: B**

**45. Who said that the ultimate goal of aversion is the state of physiological quiescence to be reached when the disturbing stimulus ceases to act upon the organism?**
**(a) E. L. Thorndike**
**(b) W. Kohler**
**(c) E. C. Tolman**
**(d) Clark Hull**
**(e) None of the above**
**Answer: C**

**46. According to E. C. Tolman, there are two aversions: fright and pugnacity. Fright is avoidance of injury and pugnacity is avoidance of:**
**(a) Interference**
**(b) Affiliation**
**(c) Motivation**
**(d) Perception**
**(e) None of the above**
**Answer: A**

**47. "Equivalence Belief' is a connection between" a positively cathected type of disturbance-object and a type of what may be called:**
**(a) An interfering object**
**(b) A sub disturbance object**
**(c) A motivating object**
**(d) A goal-oriented object**
**(e) None of the above**
**Answer: B**

**48. Who revealed that "Field expectancy" takes place when one organism is repeatedly and successfully presented with a certain environmental set-up?**
**(a) E. C. Tolman**

**(b) C. L. Hull**
**(c) E. L. Thorndike**
**(d) I.P. Pavlov**
**(e) Guthrie**
**Answer: A**

**49. Dollard and Miller related Thorndike's spread of effect to the:**
**(a) Gradient of reinforcement**
**(b) Biological constraints**
**(c) Principle of preparedness**
**(d) None of the above**
**Answer: A**

**50. Miller and Dollard are more concerned with:**
**(a) Biological factor in learning**
**(b) Social factor in learning**
**(c) Physiological and Social factors in learn ing**
**(d) Personal factors in learning**
**(e) None of the above**
**Answer: B**

**51. Mowrer's Sign learning comes close to Guthrie's contiguity and his 'solution learning' corresponds to:**
**(a) Pavlov's Classical Conditioning**
**(b) Kohler's Insightful learning**
**(c) Skinner's instrumental learning**
**(d) Thorndike's trial and error learning**
**(e) None of the above**
**Answer: C**

**52. Mowerer's two-factor theory takes into consideration the fact that:**
**(a) Some conditioning do not require reward and some do**
**(b) Every conditioning requires reinforcement**
**(c) The organism learns to make a response to a specific stimulus**
**(d) Learning is purposive and goal-oriented**
**(e) None of the above**
**Answer: A**

**53. When learning in one situation influences learning in another situation, there is evidence of:**
**(a) Avoidance learning**
**(b) Learned helplessness**
**(c) Premise of Equipotentiality**
**(d) Transfer of Training**
**(e) None of the above**
**Answer: D**

**54. If learning in situation 'A' may favourably influence learning in situation 'B', then we have:**
**(a) Positive Transfer**
**(b) Negative Transfer**
**(c) Zero Transfer**
**(d) Bilateral Transfer**

**(e) Neutral Transfer**
**Answer: A**

**55. If learning in situation 'A' has a detrimental effect on learning in situation 'B', then we have:**
**(a) Positive Transfer**
**(b) Zero Transfer**
**(c) Neutral Transfer**
**(d) Negative transfer**
**(e) None of the above**
**Answer: D**

**56. Mediation occurs when one member of an associated pair is linked to the other by means of:**
**(a) A reinforcement**
**(b) An intervening element**
**(c) Generalization**
**(d) Secondary reinforcement**
**(e) None of the above**
**Answer: B**

**57. Zero transfer is otherwise known as:**
**(a) Neutral Transfer**
**(b) Positive Transfer**
**(c) Negative Transfer**
**(d) Bilateral Transfer**
**(e) None of the above**
**Answer: A**

**58. Negative Transfer of Training is otherwise known as:**
**(a) Neutral Transfer**
**(b) Habit interference**
**(c) Zero Transfer**
**(d) Bilateral Transfer**
**(e) None of the above**
**Answer: B**

**59. "If you do not like milk, you may not like all milk products like cheese butter, ghee and curd". This is due to:**
**(a) Generalization Gradient**
**(b) Avoidance Learning**
**(c) Biological Constraints**
**(d) Transfer of Training**
**(e) None of the above**
**Answer: D**

**60. Who told, "Although Classical Conditioning is a laboratory procedure, it is easy to find real world examples."?**
**(a) B.J. Underwood (1983)**
**(b) G. H. Bower (1976)**
**(c) C. B. Osgood (1957)**
**(d) Kimble and Germazy (1980)**
**(e) Mc Geoch (1942)**
**Answer: D**

**61. According to Hull, a systematic behaviour or learning theory can be**

possible by happy amalgamation of the technique of conditioning and the:
(a) Law of Effect
(b) Law of Exercise
(c) Law of Frequency
(d) Law of Recency
(e) None of the above
Answer: A

62. The methods of verbal learning are important because:
(a) The use of standard methods for learning makes comparisons of results possible
(b) Rewards are not necessary here
(c) They minimise the effect of punishment
(d) Punishment has no effect on learning
(e) None of the above
Answer: A

63. Positive transfer of training is possible with:
(a) Dissimilar tasks
(b) Motor tasks
(c) Similar tasks
(d) Verbal tasks
(e) None of the above
Answer: C

64. A 'Skinner Box' is used for:
(a) Motor learning
(b) Verbal learning
(c) Sensory learning
(d) Problem Solving
(e) Incidental learning
Answer: D

65. Punishment is effective only when it weakens:
(a) Undesirable response
(b) Desirable response
(c) Positive response
(d) Negative response
(e) None of the above
Answer: A

66. Which one of the following psychologists is not associated with the theories of learning?
(a) Sullivan
(b) C. Hull
(c) Tolman
(d) Thorndike
(e) Guthrie
Answer: A

67. In which method, the entire list is once exposed to 'S' and then he is asked to anticipate each item in the list before it is exposed on the memory drum?
(a) Recall
(b) Recognition

**(c) Relearning and Saving**
**(d) Anticipation Method**
**(e) None of the above**
**Answer: D**

**68. The new items which are added to the original list in recognition method are known as:**
**(a) Stimulants**
**(b) Respondents**
**(c) Gradients**
**(d) Distractors**
**(e) None of the above**
**Answer: A**

**69. Learning to make new responses to identical or similar stimuli results in a:**
**(a) Negative Transfer**
**(b) Positive Transfer**
**(c) Zero transfer**
**(d) Neutral transfer**
**(e) None of the above**
**Answer: A**

**70. Both positive and negative transfers are largely the result of:**
**(a) Similarity of responses in the first and the second task**
**(b) Dissimilarity of responses in the first and the second task**
**(c) Co-ordination of responses in the first and the second task**
**(d) Both similarity and dissimilarity of responses in the first and the second task**
**(e) None of the above**
**Answer: B**

**71. The greater the similarity between the stimuli of the first task and the second task:**
**(a) The less the extent of transfer**
**(b) The greater the extent of transfer**
**(c) The minimum the extent of transfer**
**(d) No transfer occurs**
**(e) None of the above**
**Answer: D**

**72. A high positive transfer results when stimuli are similar and responses are:**
**(a) Identical**
**(b) Not Identical**
**(b) Haphazard**
**(d) Equipotential**
**(e) None of the above**
**Answer: A**

**73. It is possible to maximize a positive transfer from a class room situation to real life situation by making formal education more realistic or closely connected with:**
**(a) Real-life problems**

**(b) Imaginary problems**
**(c) Temporary problems**
**(d) Easy Problems**
**(e) None of the above**
**Answer: A**

**74. In programmed learning, the importance is placed on:**
**(a) Trial and error learning**
**(b) Latent learning**
**(c) Classical conditioning**
**(d) Operant conditioning**
**(e) None of the above**
**Answer: D**

**75. Who is regarded as the father of the 'Programmed Learning'?**
**(a) B. F. Skinner**
**(b) I. P. Pavlov**
**(c) C.L. Hull**
**(d) J.B. Watson**
**Answer: A**

**76. Who has first devised a machine for teaching in 1920?**
**(a) M. R. F. Maier**
**(b) A. Luchins**
**(c) S. L. Pressey**
**(d) H. F. Harlow**
**(e) D. O. Hebb**
**Answer: C**

**77. In the system of programmed learning, the learner becomes:**
**(a) An active agent in acquiring the acquisition**
**(b) A passive agent in acquiring the acquisition**
**(c) A neutral age in acquiring the acquisition**
**(d) Instrumental in acquiring the acquisition**
**(e) None of the above**
**Answer: A**

**78. Programmed learning:**
**(a) Is not helpful for teaching**
**(b) Is not helpful in the socialization of the child**
**(c) Is not helpful in classroom situation**
**(d) Is not helpful for teachers**
**(e) None of the above**
**Answer: B**

**79. Lewin's field theory gives more importance to behaviour and motivation and less to:**
**(a) Incentive**
**(b) Drive**
**(c) Experience**
**(d) Intelligence**
**(e) None of the above**
**Answer: C**

**80. Kurt Lewin regards the environment of the individual as his:**
**(a) life-space**
**(b) Instinctive drift**
**(c) Autoshaping**
**(d) Foresight**
**(e) None of the above**
**Answer: A**

**81. Guthrie's theory of learning is known as the learning by:**
**(a) Interpretation**
**(b) Representation**
**(c) Substitution**
**(d) Response**
**(e) None of the above**
**Answer: D**

**82. For Skinner, the basic issue is how reinforcement sustains and controls responding rather than:**
**(a) Which stimulus evokes a response**
**(b) Which response is helpful**
**(c) Which stimulus can be generalized**
**(d) Which stimulus can be discriminated**
**(e) None of the above**
**Answer: A**

**83. Who said that the event-that is drive reducing is satisfying?**
**(a) E. C. Tolman**
**(b) R. S. Woodworth**
**(c) E. L. Thorndike**
**(d) Clark H. Hull**
**(e) None of the above**
**Answer: D**

**84. Materials like food for hungry animals or water for thirsty animals are called:**
**(a) Secondary reinforcers**
**(b) Primary Reinforcers**
**(c) Intermittent reinforcers**
**(d) Fixed reinforcers**
**(e) None of the above**
**Answer: B**

**85. When a thing acquires some characteristics of a reinforcer because of its consistent association with the primary reinforcement, we call it a/an:**
**(a) Secondary Reinforcer**
**(b) Primary Reinforcer**
**(c) Fixed Reinforcer**
**(d) Intermittent Reinforcer**
**(e) None of the above**
**Answer: A**

**86. In one experiment, the chimpanzees were taught to insert poker chips in a vending machine in order to obtain grapes. When this**

**was done, they were made to pull, with all their strength, an iron bar attached to a similar machine to obtain poker chips. The chimpanzees learned it too, because they were allowed to cash those chips for grapes afterwards. Here the token chips had only a/an:**
**(a) Primary Reinforcing Value**
**(b) Extra Reinforcing Value**
**(c) Special Reinforcing Value**
**(d) Secondary Reinforcing Value**
**(e) None of the above**
**Answer: A**

**87. Partial Reinforcement is often called:**
**(a) Intermittent Reinforcment**
**(b) Schedules of Reinforcement**
**(c) Span of Reinforcement**
**(d) Reinforcement Schedule**
**(e) None of the above**
**Answer: A**

**88. Reinforcing a given response only for sometime on trials is known as:**
**(a) Partial Reinforcement**
**(b) Continuous Reinforcement**
**(c) Reinforcement Schedule**
**(d) No Reinforcement**
**(e) None of the above**
**Answer: A**

**89. Most human habits are reinforced in a:**
**(a) Variable fashion**
**(b) Constant fashion**
**(c) Partial Manner**
**(d) Particular Time span**
**(e) None of the above**
**Answer: A**

**90. Most human habits are resistent to extinction because these are reinforced:**
**(a) In a constant fashion**
**(b) All the times**
**(c) Every now and then**
**(d) In a variable fashion**
**(e) Very often**
**Answer: D**

**91. Which type of learning experiments show how the behaviour of animals can be controlled or shaped in a desired direction by making a careful use of reinforcement?**
**(a) Classical conditioning**
**(b) Operant conditioning**
**(c) Latent Learning**
**(d) Sign Learning**
**(e) None of the above**
**Answer: B**

**92. In Operant Conditioning, he strength of an operant response is usually measured in terms of the frequency of lever pressing:**
**(a) Per unit of time**
**(b) In every five minutes**
**(c) As a whole**
**(d) In a day**
**(e) None of the above**
**Answer: A**

**93. The method we use in memorising poetry is called:**
**(a) Paired-associate learning**
**(b) Distributed learning**
**(c) Serial memorisation**
**(d) Massed learning**
**(e) Syntactic Memorisation**
**Answer: C**

**94. Shifting from right-hand driving in (in U.S.A.) to a left-hand driving (in India) is an illustration of:**
**(a) Negative transfer of training**
**(b) Positive transfer of training**
**(c) Neutral transfer of training**
**(d) Both neutral and positive transfer of training**
**(e) None of the above**
**Answer: A**

**95. The replacement of one conditioned response by the establishment of an incompatible response to the same conditioned stimulus is known as:**
**(a) Backward Conditioning**
**(b) Counter Conditioning**
**(c) Forward Conditioning**
**(d) High order conditioning**
**(e) None of the above**
**Answer: B**

**96. Experimental literature revealed that experiments on latent learning were done by:**
**(a) Tolman and Honzik (1930)**
**(b) Gibson and Harlow**
**(c) Pavlov and Watson**
**(d) Kohler and Wertheimer**
**Answer: A**

**97. Working with monkeys, Harlow (1949) propounded that the general transfer effect from one situation to another may be accounted for by the concept of:**
**(a) "Learning how to learn" or "Learning Sets"**
**(b) Sign learning**
**(c) Latent learning**
**(d) Gradient of learning**
**(e) Plateau**
**Answer: A**

**98. Proactive Inhibition refers to the learning of 'A' having a detrimental effect on the learning of 'B'. So it is a:**
**(a) Neutral transfer of effect**
**(b) Zero transfer of effect**
**(c) Positive transfer of effect**
**(d) Negative transfer of effect**
**(e) None of the above**
**Answer: D**

**99. Who has defined "perceptual learning" as "an increase in the ability to extract information from the environment as a result of expe-rience or practice with the stimulation coming from it."?**
**(a) I. P. Pavlov**
**(b) Wertheimer**
**(c) B. F. Skinner**
**(d) Eleanor Gibson (1969)**
**(e) J.B. Watson**
**Answer:D**

**100. To distinguish the calls of birds:**
**(a) Sign learning is necessary**
**(b) Perceptual learning is needed**
**(c) Operant conditioning would be conducive**
**(d) Insight is needed**
**(e) CR will be helpful**
**Answer: B**

**101. Delusions are characteristically seen in:**
**A. Schizophrenia**
**B. Delirium**
**C. Dementia**
**D. Depression**
**Answer: A**

**102. The presence of delusions, hallucinations, and disturbed cognitive function indicates:**
**A. Organic brain syndrome**
**B. Paranoid psychosis**
**C. Dissociative hysteria**
**D. Obsessive-compulsive disorder**
**Malingering-external motivation + Factitious disorder intentionally produced physical/psychological symptoms just to assume the sick role.**
**Answer: A**

**103. The difference between neurosis and psychosis is:**
**A. Severity**
**B. Insight**
**C. Clinical features**
**D. Duration of onset**
**Features of psychosis include Gross impairment in reality testing**
**Answer: B**

**104. Cognition is:**

**A. Perception**
**B. Thought**
**C. Behaviour**
**D. Feeling**
**Cognition – thinking**
**Conation – action**
**Affect – feeling**
**Answer: B**

**105. Delusion is a disorder of:**
**A. Perception**
**B. Thinking**
**C. Intelligence**
**D. Judgment**
**Hallucination, illusion – are disorders of perception**
**Answer: B**

**106. Hallucination is a disorder of:**
**A. Perception**
**B. Thinking**
**C. Intelligence**
**D. Memory**
**Answer: A**

**107. Primary delusions are characterised by disorders of:**
**A. Thought**
**B. Obsession**
**C. Hallucination**
**D. Loosening of association**
**Answer: A**

**108. All the following are true about hallucinations, except:**
**A. It represents a state of inner subjective space**
**B. It is dependent of the observer**
**C. It is as vivid as sensory perception**
**D. It occurs in the absence of perceptional stimulus**
**Answer: B**

**109. The main excitatory neurotransmitter in the CNS is: (AI-2003, Pg-W9-SOP)**
**A. Cysteate**
**B. Acetylcholine**
**C. Aspartate**
**D. Glutamate**
**Inhibitory neurotransmitter is GABA**
**Answer: D**

**110. 25-years house wife come to the psychiatry outpatients department complaining that her nose was longer than usual. She felt that her husband did not like her because of the deformity and had developed relationship with the neighboring girl. Further she complained that people made fun of her. It was not possible to convince her that there was no deformity. Her symptoms include:**
**A. Delusion**

**B. Depersonalization**
**C. Depression**
**D. Hallucination**
**Delusion is a disorder of thinking, which is a firm, fixed, unshakable, and held with strong conviction, irrespective of sociocultural and educational background. The content of it being bizarre but not always.**
**Answer: A**

**111. Neologism is:**
**A. Minting of words**
**B. Totally**
**C. Has some meaning**
**D. Modification of word**
**8B 9D 10A 11B**
**Neologisms:**
**Newly formed words or phrases whose derivation cannot be understood parathions – word approximations where normal words are used in an unconventional or distorted way, but the derivation can be understood.**
**Answer: B**

**112. Delusion is a false belief which is:**
**A. Reasonable**
**B. Comprehensible**
**C. Both of the above**
**D. None of the above**
**Delusion is a false unshakable belief which is not amenable to reasoning and us not in keeping with the patient's sociocultural and educational background.**
**Answer: B**

**113. Auditory hallucinations are seen in all of the following except:**
**A. Hysteria**
**B. Mania**
**C. Amphetamine toxicity**
**D. Schizophrenia**
**Answer: A**

**114. Tactile hallucinations are associated with:**
**A. Schizophrenia**
**B. Cocaine psychosis**
**C. Temporal lobe epilepsy**
**D. All of the above**
**Answer: D**

**115. Pseudo-hallucinations are not said symptoms of:**
**A. Hysteria**
**B. Schizophrenia**
**C. Pseudo-neurotic schizophrenia**
**D. Malingering**
**Answer: A**

**116. Delusion is seen in all, except:**

**A. Mania**
**B. Depression**
**C. Anxiety neurosis**
**D. Schizophrenia**
**Answer: C**

**117. Delusion is a disorder of:**
**A. Perception**
**B. Thought**
**C. Personality**
**D. Affect**
**Answer: B**

**118. Delusion is:**
**A. A feeling of loss of sensation**
**B. Not able to get proper answer**
**C. A false belief**
**D. An uncomfortable sensation**
**Delusions are false unshakable beliefs which are not in keeping with patient's sociocultural and educational background.**
**Answer: C**

**119. Thought disorder is seen in:**
**A. Obsessive-compulsive disorder**
**B. Anxiety neurosis**
**C. Schizophrenia**
**D. Psychopathic personality**
**Autistic thinking, loosening of association are forms of though disorder seen in schizophrenia.**
**Answer: C**

**120. A false belief unexplained by reality, which is shared by a number of people is:**
**A. Delusion**
**B. Obsession**
**C. Superstition**
**D. Illusion**
**Answer: C**

**121. One of the following is a disorder of thought:**
**A. Illusion**
**B. Hallucination**
**C. Delirium**
**D. Delusion**
**Illusion and hallucination are disorders of perception Delusion is a disorder of content of thought Delirium is an organic condition where is there is an acute confessional state.**
**Answer: D**

**122. Deja vu Phenomenon is:**
**A. Feeling palpable music**
**B. Feeling nauseating smell**
**C. Fear of impending doom**
**D. Families to unfamiliar surroundness**
**Illusion of familiarity in unfamiliar situations is Deja vu.**
**Deja Pense – related to thoughts**

**Deja entendu – related to auditory perception.**
**Answer: D**

**123. Depersonalisation is a disorder of:**
**A. Mood**
**B. Thought**
**C. Perceptions**
**D. Cosmetic**
**Other disorders of perceptions are Hallucinations and Illusions.**
**Answer: C**

**124. The most common cause of mood congruent delusion is:**
**A. Obsessive-compulsive neurosis**
**B. Schizophrenia**
**C. Dementia**
**D. Mania**
**Mood-congruence refers to occurrence of psychiatry symptoms in keeping with mood state.**
**Answer: D**

**125. Visual hallucinations are seen in:**
**A. Alcoholism**
**B. Mania**
**C. Depression**
**D. Phobia**
**Seen in Delirium tremens.**
**Answer: A**

**126. Tactile hallucination is a feature of:**
**A. Anxiety neurosis**
**B. Cocaine poisoning**
**C. Morphine withdrawal**
**D. Schizophrenia**
**Delirium and anxiety neurosis can also occur with cocaine.**
**Answer: B**

**127. "Phantom limb" in an example of:**
**A. Delusion**
**B. Illusion**
**C. Phi phenomenon**
**D. Hallucination**
**E. Fantasy**
**Answer: D**

**128. 'Mirage' is an example of:**
**A. Illusion**
**B. Delusion**
**C. Hallucination**
**D. Extrasensory perception**
**E. Fantasy**
**Answer: A**

**129. Delusion is not seen in:**
**A. Anxiety**
**B. Mania**
**C. Depression**
**D. Schizophrenia**

**Answer: A**

**130. Cognition means:**
**A. Behaviour**
**B. Thought**
**C. Perception**
**D. Feeling**
**There are three psychiatric domains. Cognition (thought)**
**Affect (Feeling)**
**Conation (action)**
**Equilibrium normally exists between the domains.**
**Answer: B**

**131. Delusions of influence are characteristic of:**
**A. Obsessive state**
**B. Schizophrenia**
**C. Depression**
**D. Dramatization**
**Delusion of control/influence is seen commonly in schizophrenia.**
**Answer: B**

**132. Delusions and hallucinations are known as:**
**A. Psychotic symptoms**
**B. Neurotic symptoms**
**C. Behavioral symptoms**
**D. Psychosomatic symptoms Term psychosis is defined as Gross impairment of reality testing Loss of weight**
**Pressure of characteristic symptoms like delusions and hallucination.**
**Answer: A**

**133. The commonest disorder of perception is:**
**A. Delusion**
**B. Hallucination**
**C. Passivity**
**D. Compulsion**
**Hallucination and passivity are disorders of perception**
**Compulsion delusions are disorders of thought.**
**Answer: B**

**134. Therapeutic community concept was propagated by:**
**A. Freud**
**B. Adler**
**C. Maxwell Jones**
**D. Watson. J**
**Answer: C**

**135. Psychoanalysis was found by:**
**A. Freud**
**B. Jung**
**C. Adler**
**D. Eysenck**
**Answer: A**

**136. A false sensory perception in the absence of external stimulus is:**
**A. Hallucination**
**B. Illusion**
**C. Delusion**
**D. Depersonalization**
**Answer: A**

**137. Loss of insight occurs in:**
**A. Anxiety neurosis**
**B. Schizophrenia**
**C. Psychosomatic disorder**
**D. MDP**
**Loss of weight is a feature of psychosis. It is seen both in schizophrenia and manic phase of MDP but prominent in schizophrenia.**
**Answer: B**

**138. Grimacing is a feature of:**
**A. Catatonic schizophrenia**
**B. Hebephrenic schizophrenia**
**C. Paranoid schizophrenia**
**D. Juvenile schizophrenia**
**Answer: A**

**139. Flashbacks are seen with:**
**A. LSD**
**B. Amphetamine**
**C. Cocaine**
**D. Opiates**
**Flashback is a spontaneous recurrence of Drug use experience in drug free state.**
**Answer: A**

**140. Loss of insight occurs in:**
**A. Hysteria**
**B. Schizophrenia**
**C. Obsessive-compulsive neurosis**
**D. Somatoform disorders**
**Loss of insight occurs in psychosis except schizophrenia all the other three disorders belongs to neuroses.**
**Answer: B**

**141. Confabulation is a defect of:**
**A. Memory**
**B. Intelligence**
**C. Affection**
**D. Concentration**
**Answer: A**

**142. 'La belle indifference' is seen in:**
**A. Dissociative disorder**
**B. Phobia**
**C. Obsessive-compulsive disorder**
**D. Depersonalization disorder**
**Lack of concern towards symptoms in patients with dissociative disorder.**
**Answer: A**

**143. Ganser's sy**

**ndrome is associated with:**
**A. Repeated lying**
**B. Approximate answers**
**C. Confabulation**
**D. Malingering**
**Ganser's syndrome is a dissociative disorder. It is also called hysterical pseudo dementia.**
**Answer: B**

**144. Nihilistic delusion is seen in:**
**A. Depression**
**B. Schizophrenia**
**C. Mania**
**D. OCN**
**Nihilistic delusion is mood – congruent type of delusion seen in depression.**
**Answer: A**

**145. Neologism is characteristic of:**
**A. Mania**
**B. Schizophrenia**
**C. Depression**
**D. OCN**
**Answer: B**

**146. An 18-year-old hears voices discussing him in the third person. He has**
**A. TLE**
**B. Depression**
**C. Mania**
**D. Schizophrenia**
**Answer: D**

**147. To become unfamiliar of familiar situation is called:**
**A. Deja vu**
**B. Jamais vu**
**C. Deja pence**
**D. Deja entendu Explanation:— Deja vu—illusion of visual recognition in which a new situation is incorrectly regarded as a repetition of a previous memory. Jamais vu—False feeling of unfamiliarity with a real situation that a person has experienced. Deja pence—Illusion that a new thought is recognised as a thought previously felt or expressed. Deja entendu—Illusion of auditory recognition.**
**Answer: B**

**148. The term "free association" was coined by:**
**A. Adler**
**B. Erickson**
**C. Freud**
**D. Jung**
**Other terms coined by Freud- psychoanalysis, oedipus complex, electra complex, penis envy, primal scene, pleasure principle.**

**Answer: C**

**149. Who experimented the instrumental learning?**
**A. Gustav**
**B. Sigmund Freud**
**C. Skinners**
**D. Karl Jug**
**Also called as operant conditioning.**
**Answer: C**

**150. Psychosis is characterized by all, except:**
**A. Contact with reality is maintained**
**B. Positive symptoms are usually present**
**C. Impaired judgment**
**D. Insight is lost.**
**The first symptom for psychosis is a gross impairment in reality testing.**
**Answer: A**

**151. Which of the following is most specific of psychosis?**
**A. Neologism**
**B. Incoherence**
**C. Perseverance**
**D. Pressure of speech**
**Answer: A**

**152. A 23-year-old man has a fight with a boy in his neighborhood. The next day he feels two policemen are following him to arrest him. He is agitated and pales up and down him room. He feels that his neighbors are controlling his mind by sending waves from an electric device. He is suffering from:**
**A. Delusions of persecution**
**B. Though insertion**
**C. Passivity**
**D. Depression**
**Answer: A**

**153. Early in psychiatric interview, it is important for the physician to:**
**A. Let patients talk about what is bothering them**
**B. Obtain information about the patient's mood**
**C. Record the family history**
**D. Inform the patient of the fee**
**E. Obtain details of any past psychiatric illness**
**Answer: C**

**154. Epistemology is the branch of philosophy which deals with the theories of**
**1 Reality**
**2 Existence**
**3 Knowledge**
**4 Values**
**Answer: Knowledge**

**155. "Things as they are and as they are likely to be encountered in life rather than words" was the slogan of the**

**1 Pragmatists**
**2 Realists**
**3 Idealists**
**4 Existentialists**
**Answer:Realists**

**156. Who advocated the creation of a classless society ?**

**1 Plato**
**2 Auguste Comte**
**3 M.K. Gandhi**
**4 Karl Marx**
**Answer:Karl Marx**

**157. The right to free and compulsory education for children between age group of 6 to 14 has been inserted in Indian Constitution as**

**1 Article 46**
**2 Article 16**
**3 Article 45A**
**4 Article 21A**
**Answer: Article 21A**

**158. Who advocated the logical analysis of language for getting the true meaning ?**

**1 A.J. Ayer**
**2 Bertrand Russel**
**3 Morris L. Biggie**
**4 G.E. Moore**
**Answer: A.J. Ayer**

**159. Sociology of Education is**

**1 A branch of Anthropology**
**2 A study of the Society**
**3 An analysis of Sociological processes involved in the institutions of Education.**
**4 A science which studies primitive societies.**
**Answer:An analysis of Sociological processes involved in the institutions of Education.**

**160. Schools are basically social institutions as**

**1 They preserve and instil the values of our culture in future generations.**
**2 They suggest ways and means for social progress.**
**3 They suggest solutions to social problems.**
**4 They are established by the society.**

**Answer:They preserve and instil the values of our culture in future generations.**

**161. Which is not a criterion used consistently for placing people in a particular social class ?**

**1 Race**
**2 Religion**
**3 Knowledge**
**4 Wealth**
**Answer: Knowledge**

**162. Use of Science and Technology in replacing existing social practices is termed as**

**1 Socialization**
**2 Westernization**
**3 Sanskritization**
**4 Modernization**
**Answer:Modernization**

**163. Which of the following chains represents the change processes underlying educational system of Free India ?**

**1 Psychological change – Social change – Political change – Educational change.**
**2 Political change – Social change – Psychological change– Educational change.**
**3 Social change – Psychological change – Political change – Educational change.**
**4 Educational change – Social change – Psychological change.**
**Answer: Political change – Social change – Psychological change– Educational change.**

**164. Use of Science and Technology in replacing existing social practices is termed as**

**1 Socialization**
**2 Westernization**
**3 Sanskritization**
**4 Modernization**
**Answer: Modernization**

**165. Equality of opportunities in education implies that each student**

**1 passes examination with first division.**
**2 gets equal number of books and stationery.**
**3 gets facilities according to his abilities and interests.**
**4 gets facilities according to his potential and level in the society.**

**Answer:gets facilities according to his abilities and interests.**

**166. Which of the following is not a principle of development ?**

**1 Principle of continuity.**
**2 Principleof individual difference.**
**3 Principle of proceeding from specific to general response.**
**4 Principle of integration.**
**Answer:Principle of proceeding from specific to general response.**

**167. Development of language in children, according to B.F. Skinner, is the result of**

**1 Training in grammar**
**2 Imitation and reinforcement**
**3 Innate abilities**
**4 Maturation**
**Answer: Imitation and reinforcement**

**168. Behaviour pattern that increases in frequency when followed by a reward is known as**

**1 Shaping**
**2 Classical Conditioning**
**3 Generalization**
**4 Operant Conditioning**
**Answer:Operant Conditioning**

**169. Find out the odd one :**

**1 Originality**
**2 Punctuality**
**3 Flexibility**
**4 Fluency**
**Answer: Punctuality**

**170. Who propounded Self Theory of Personality ?**

**1 Kretschmer**
**2 Allport**
**3 Eysenck**
**4 Roger**
**Answer:Roger**

**171. Archimedes found the solution of his problem when he was in his bath tub. This will come under which step of process of creativity ?**

**1 Preparation**
**2 Incubation**
**3 Illumination**
**4 Verification**
**Answer: Illumination**

**172. The pioneer of functionalism is**

**1 Wilhelm Wundt**
**2 William James**
**3 J.B. Watson**
**4 Kurt Lewin**
**Answer:William James**

**173. Nihar fails in the examination and attributes his failure to the framing of the faulty question paper. Which defence mechanism does he use ?**
**1 Projection**
**2 Compensation**
**3 Identification**
**4 Rationalisation**
**Answer: Rationalisation**

**174. Which of the following is not a characteristic of Naturalistic Inquiry ?**
**1 Multiple Realities**
**2 Generalisation**
**3 Human Relations**
**4 Value Based Research**
**Answer: Generalisation**

**175. Which of the following variances is not controlled or manipulated in a research design ?**
**1 Variance of independent variable.**
**2 Variance of dependent variable.**
**3 Variance of extraneous variables.**
**4 Error variance**
**Answer:Variance of dependent variable.**

**176. Which of the following is not a criterion for the statement of a good research problem ?**
**1 Expression of relationship between/among variables.**
**2 Clarity and unambiguousness.**
**3 Possibility of empirical testing.**
**4 Possibility of use of statistical analysis.**
**Answer:Possibility of use of statistical analysis.**

**177. Which of the following variables is continuous ?**
**1 Attitude towards school**
**2 Family size in a locality**
**3 Marital status of College students**
**4 Religious affiliation of workers.**
**Answer:Attitude towards school**

**178. Which of the following is a measure of location ?**
**1 Mode**
**2 Mean**
**3 Percentile**
**4 Standard Deviation**
**Answer: Percentile**

**179. An investigator wants to study the vocational aspirations of visually challenged children in a wide geographical area. He should select his sample by using**
**1 Sample Random sampling**
**2 Stratified sampling**

**3 Purposive sampling**
**4 Convenient sampling**
**Answer: Purposive sampling**

**180. The distribution of a large number of means based on samples of the sample size selected from the same population is known as**
**1 normal distribution**
**2 sampling distribution**
**3 standard distribution**
**4 rectangular distribution**
**Answer: sampling distribution**

**181. Two variables X and Y are correlated. This means that the two variables**
**1 cause variation in each other**
**2 measure the same trait**
**3 vary together**
**4 vary independently**
**Answer: vary together**

**182. When the questions are presented to the respondents in a face-to-face situation and the interviewer fills out the query rather than the subjects it is known as**
**1 An inventory**
**2 A questionnaire**
**3 A schedule**
**4 A test**
**Answer: A schedule**

**183. Who said this "Education is man-making. It is that by which character is formed, strength of mind is increased, intellect is expanded and by which man can stand on his own feet" ?**
**1 Vivekananda**
**2 Tagore**
**3 Dayanand Saraswati**
**4 None of these**
**Answer :Vivekananda**

**184. Purpose of creation of the universe and its relation to man and god is discussed in**
**1 Metaphysics**
**2 Ethics**
**3 Epistemology**
**4 None of these**
**Answer: Metaphysics**

**185. Which of the following agency regulates education ?**
**1 Church**
**2 State**
**3 School**
**4 Library**
**Answer: State**

**186. "The greatness of a nation is to be measured not by its material power and wealth but by the**

**intercultural relationship of its people." Who said this ?**
**1 Dr. Radhakrishnan**
**2 Tagore**
**3 Vivekananda**
**4 Gandhi**
**Answer:Dr. Radhakrishnan**

**187. Which of the following does not specify Max Weber's concept of social stratification**
**1 Educational Status**
**2 Income and Wealth**
**3 Political Power**
**4 Social Prestige**
**Answer: Educational Status**

**188. If rules of multiplication helps in learning correlation or regression, then it is an example of**
**1 Sequential transfer**
**2 Horizontal transfer**
**3 Negative transfer**
**4 Vertical transfer**
**Answer:Vertical transfer**

**189. According to Freud, Super Ego is properly developed during**
**1 latency period**
**2 anal period**
**3 phallic period**
**4 none of these**
**Answer: latency period**

**190. When response is based on uncommon area of the blot, it is denoted by**
**1 S**
**2 Dd**
**3 DW**
**4 DdW**
**Answer:Dd**

**191. Individual psychology of personality was given by**
**1 A. Adler**
**2 Jung**
**3 Eysenck**
**4 None of these**
**Answer: A. Adler**

**192. Which is the highest level of concept formation ?**
**1 Formal level**
**2 Sensory level**
**3 Concrete level**
**4 None of these**
**Answer: Formal level**

**193. Which of the following is the apex body in the area of Teacher Education in India ?**
**1 UGC**
**2 MHRD**
**3 NCTE**
**4 NCERT**

**Answer: NCTE**

**194. Who have signed MOU for accreditation of Teacher Education Institutions in India ?**
**1 NAAC and UGC**
**2 NCTE and NAAC**
**3 UGC and NCTE**
**4 None of the above**
**Answer:NCTE and NAAC**

**195. As per NCTE norms, what should be the pattern of teaching staff for a unit of 100 students B.Ed. level ?**
**1 1 + 7**
**2 1 + 9**
**3 1 + 10**
**4 1 + 5**
**Answer:1 + 7**

**196. There are three phases of teaching given by P. Jackson, which of the following is incorrect one ?**
**1 Pre-active phase**
**2 Underactive phase**
**3 Interactive phase**
**4 Post-active phase**
**Answer:Underactive phase**

**197. Which of the following is the least important aspect of the teachers' role in the guidance of learning ?**
**1 The development of insight into what constitutes an adequate performance.**
**2 The development of insight to overcome the pitfalls and obstacles.**
**3 The provision of encouragement and moral support.**
**4 The provision of continuous diagnostic and remedial help.**
**Answer: The development of insight to overcome the pitfalls and obstacles.**

**198. Which of the following qualities of a teacher will be liked most by you ?**
**1 Idealistic philosophy**
**2 Compassion**
**3 The Discipline Run**
**4 Entertaining**
**Answer:Compassion**

**199. The most important challenge for a teacher is**
**1 to maintain discipline in the classroom.**
**2 to make students do their homework.**
**3 to prepare the question-bank.**
**4 to make teaching process enjoyable.**

**Answer:to make teaching process enjoyable.**

**200. Techno-Pedagogic competency is**
**1 a science of using technology in teaching.**
**2 a technique of combining principles of technology and principles of teaching.**
**3 a set of skills of interweaving technology into teaching and learning both scientifically and aesthetically.**
**4 a competence to develop techno-pedagogic systems in education.**
**Answer: a set of skills of interweaving technology into teaching and learning both scientifically and aesthetically.**

**201. Psycho-analytic approach of counselling was first introduced by**
**1 Adler**
**2 Jung**
**3 Freud**
**4 None of these**
**Answer:Freud**

**202. Which of the following does not belong to the category of non-probability sample ?**
**1 Quota sample**
**2 Multi-stage sample**
**3 Purposive sample**
**4 Incidental sample**
**Answer:Multi-stage sample**

**203. The research proposals sent to research institutes for financial assistance must have**
**1 The whole plan and procedure**
**2 Budget requirements and time schedule**
**3 Definite objectives of research**
**4 None of the above**
**Answer:Budget requirements and time schedule**

**204. Which of the following is not an approach of analysis of qualitative data ?**
**1 Logical Analysis**
**2 Criterion Analysis**
**3 Content Analysis**
**4 Inductive Analysis**
**Answer:Criterion Analysis**

**205. Internal criticism is done**
**1 to verify the accuracy of the source.**
**2 to verify the authenticity of the source.**
**3 Both of these**
**4 None of these**

**Answer: to verify the accuracy of the source.**

**206. Which of the following is described as Magna-Carta of Indian Education ?**
**1 Sargent Commission**
**2 Wood's Despatch**
**3 Macaulay Minutes**
**4 Hunter Commission**
**Answer: Macaulay Minutes**

**207. "Rising knowledge to wisdom is real education" was said by**
**1 Rigveda**
**2 Chhandogya Upanishad**
**3 Samaveda**
**4 Bhagvadh Geeta**
**Answer: Chhandogya Upanishad**

**208. The Oriental School of Thought is related to**
**1 knowledge of science**
**2 classical literature**
**3 conservation of fashion**
**4 learning of natives**
**Answer:classical literature**

**209. 'Project is a whole-hearted purposeful activity proceeding on a social environment", it was defined by**
**1 John Dewey**
**2 Ballard**
**3 Kilpatrick**
**4 Adamson**
**Answer:Kilpatrick**

**210. Who said that the school be made as miniature society ?**
**1 Skinner**
**2 Thorndike**
**3 Herbert**
**4 Dewey**
**Answer:Dewey**

**210. 'Socialization' is a process by which the individual is adapted to his**
**1 classroom environment**
**2 social environment**
**3 political environment**
**4 cultural environment**
**Answer: social environment**

**211. The movement from one social class to another is known as**
**1 social status**
**2 social control**
**3 social change**
**4 social mobility**
**Answer: social mobility**

**212. 'Cultural Lag' is the term used by**

**1 Ogburn**
**2 Pyne**
**3 Weber**
**4 Marx**
**Answer: Ogburn**

**213. District Primary Education Programme (DPEP) was started in**
**1 1990**
**2 1994**
**3 1998**
**4 1996**
**Answer:1994**

**214. Supervision is a continuous activity whereas Inspection is a**
**1 general activity in a common place**
**2 special activity in a given moment**
**3 complex activity in a situation**
**4 specific activity in a specific time**
**Answer: specific activity in a specific time**

**215. Who propounded the 'self' theory of personality ?**
**1 Allport**
**2 Kretschmar**
**3 Eysenck**
**4 Roger**
**Answer: Roger**

**216. University Education Commission constituted in 1948 was appointed by**
**1 Ministry of Human Resource Development**
**2 Ministry of Education**
**3 NCERT**
**4 ICSSR**
**Answer: ICSSR**

**217. Education falls under the**
**1 Concurrent List**
**2 Fundamental Rights**
**3 Constitution of India**
**4 State List**
**Answer:Concurrent List**

**218. Curriculum means**
**1 all the experiences which students get in school.**
**2 subject that are transferred by the faculty.**
**3 syllabus prescribed for the course.**
**4 class experiences, sports andgames.**
**Answer:all the experiences which students get in school.**

**219. Programmed learning is based on the principles of**
**1 Conditioned Learning Theory**
**2 Cognitive Learning Theory**
**3 Gestalt Learning Theory**

**4 Operant-conditioning**
**Answer:Operant-conditioning**

**220. According to Piaget, at what stage does abstract thinking begin to develop ?**
**1 Sensory motor**
**2 Pre-operational**
**3 Concrete operational**
**4 Formal operational**
**Answer:Formal operational**

**221. Which of the following is the incorrect pair ?**
**1 Sign Theory of – Tolman Learning**
**2 Field Theory of – Lewin Learning**
**3 Social Learning – Bruner Theory**
**4 Trial and error – Thorndike Theory**
**Answer: Social Learning – Bruner Theory**

**222. Which is the most effective reinforcement schedule according to operant conditioning theory of learning for stable learning ?**
**1 Continuous reinforcement**
**2 Fixed ratio reinforcement**
**3 Variable ratio reinforcement**
**4 Fixed interval reinforcement**
**Answer: Variable ratio reinforcement**

**223. Xerophthalmia is a result of insufficient amount of**
**1 Vitamin C**
**2 Vitamin B**
**3 Vitamin D**
**4 Vitamin A**
**Answer: Vitamin A**

**224. A child who has unusual difficulty in oral instruction may have the following impairment**
**1 Intellectual disability**
**2 Cerebral Palsy**
**3 Hearing impairment**
**4 Visual impairment**
**Answer: Hearing impairment**

**225. The child who reads numbers wrongly has the following learning disability**
**1 Dyscrasia**
**2 Dyslexia**
**3 Dyspepsia**
**4 Dyscalculia**
**Answer:Dyslexia**

**226. The child having the difficulty in picking up objects is suspected to have**
**1 Lower level of intellectual function**
**2 Sight impairment**
**3 Speech impairment**

**4 Locomotor impairment**
**Answer: Locomotor impairment**

**227. Delinquency is committed by the children of the age group**
**1 8 – 18 years**
**2 6 – 14 years**
**3 7 – 15 years**
**4 9 – 19 years**
**Answer:8 – 18 years**

**228. Which of the following philosophies are most tilted to individualism ?**
**1 Jainism**
**2 Samkhya**
**3 Buddhism**
**4 None of these**
**Answer: Jainism**

**229. Research means**
**1 Searching again and again**
**2 Finding solution to any problem**
**3 Scientific approach to new truth**
**4 Conducting experiment**
**Answer: Scientific approach to new truth**

**230. Which of the following is the first step in the research process ?**
**1 Searching sources of information.**
**2 Survey of related literature.**
**3 Identification of a broad area of research.**
**4 Searching for solution to problem.**
**Answer: Searching for solution to problem.**

**231. If a researcher conduct a research on finding out which administrative style contributes more to institutional effectiveness, this will be an example of**
**1 Expost facto research**
**2 Action research**
**3 Applied research**
**4 Fundamental research**
**Answer: Action research**

**232. A researcher is generally expected to**
**1 study the existing literature in a field.**
**2 generate new principles and theories.**
**3 synthesize the ideas given by others.**
**4 evaluate the findings of a study.**
**Answer:generate new principles and theories**

**233. The Government of India conducts Census after every 10 years. The method of research used in this process is**

**1 Case Study**
**2 Developmental**
**3 Survey**
**4 Experimental**
**Answer: Survey**

**234. Two variables X and Y are significantly correlated. This means that**
**1 X causes variation in Y.**
**2 Y causes variation in X.**
**3 X and Y vary together.**
**4 No such conclusion may be drawn.**
**Answer: X and Y vary together.**

**235. Which of the following types of studies results in findings which could not be generalized to other situations ?**
**1 Descriptive**
**2 Historical**
**3 Experimental**
**4 Causal Comparative**
**Answer: Historical**

**236. The Rosarch Inkblot test consists of**
**1 Five black and five coloured cards**
**2 Ten black and ten white cards**
**3 Five black and white & five multi-coloured cards**
**4 Ten multi-coloured cards**
**Answer: Five black and white & five multi-coloured cards**

**237. Which of the following terms is relevant to a qualitative study ?**
**1 Comparison**
**2 Prediction**
**3 Correlation**
**4 Exploration**
**Answer: Exploration**

**238. Which of the following is a characteristic feature only of experimental studies ?**
**1 Control of extraneous variables.**
**2 Study of cause and effect relationship.**
**3 Observing variation in the dependent variable.**
**4 Manipulation of treatment variable.**
**Answer:Manipulation of treatment variable.**

**239. When a researcher checks the genuineness and authenticity of the source material, it is known as**
**1 External validity**
**2 External criticism**
**3 Concurrent validity**
**4 Internal consistency**
**Answer:External criticism**

**240. An investigator studied the census data for a given area and prepared a write-up based on them. Such a write-up is called**

**1 Research Paper**

**2 Article**

**3 Thesis**

**4 Research Report**

**Answer:Article**

**241. A school counselor is planning a guidance lesson for seventh- and eighth-grade students. Which of the following instructional approaches would likely be most responsive to the developmental needs of students in this age range?**

1. **small-group activities that involve active participation**
2. **open-ended activities that encourage free exploration**
3. **counselor-directed activities that are highly structured**
4. **individual activities that encourage friendly competition**

**Answer : A.**

**242. Lev Vygotsky's theory of human cognition and learning emphasizes which of the following concepts?**

1. **the role of trial and error in learning**
2. **learning as a conditioned response to external stimuli**
3. **the role of social interaction in learning**
4. **learning as a process that unfolds in a sequence of stages**

**Answer : C**

**243. A school counseling department has been asked by the principal to implement a suicide prevention initiative at the school. Which of the following strategies would be most effective for the counselors to use in collaborating with teachers on this effort?**

1. **encouraging teachers to make referrals to help identify the students most at risk of suicide**
2. **meeting with teachers to plan how best to integrate the initiative into the existing school program**
3. **training teachers to deliver a suicide prevention unit through classroom guidance lessons**
4. **arranging for teachers to be responsible for publicizing the initiative throughout the school community**

**Answer : B**

**244. A school counselor wishes to evaluate the impact and effectiveness of a developmental guidance unit on discrimination and harassment. Which of the following strategies would be the best to use for such an evaluation?**

1. **surveying the opinions of faculty and staff on whether such behaviors have decreased**
2. **interviewing parents/guardians about types of behaviors being demonstrated by their children at home**
3. **using a spreadsheet to track incident reports related to such behavior at school**
4. **soliciting feedback from students who are participating in behavior-related counseling groups**

**245. A school counselor wants to facilitate ongoing evaluation and feedback with regard to the counseling program's individual planning component. The most effective strategy for this purpose would be to:**

1. **interview students with whom the counselor has conducted individual planning to discuss how the experience helped them and how it might be improved.**
2. **maintain a chart of each student seen for individual planning, the amount of time spent with each student, and the primary issues and topics addressed.**
3. **conduct periodic comparisons between the academic records of students who have been seen for individual planning and those of students who have not.**
4. **ask the teachers of students who have received individual planning services to inform the counselor of any changes they notice in their students afterward.**

**Answer : A.**

**246. After collecting referral data from teachers, an elementary school counselor concludes that it will be necessary to implement several small counseling groups focused on social skills. When selecting the members for each group, the counselor could best promote group effectiveness by:**

1. assembling groups of students whose members share similar backgrounds and values.
2. creating groups whose members are already friends.
3. establishing groups in which at least one member is a positive role model for other students.
4. forming groups that have fewer than five members.

Answer : C.

247. In response to a large caseload, a school counselor decides to implement small-group counseling as an efficient way to meet students' needs. Which of the following steps would be best for the counselor to take first when implementing such counseling?

1. obtaining informed consent from parents/guardians
2. conducting a needs assessment to identify potential topics and participants
3. developing goals and an action plan for the group
4. publicizing the decision to administrators, teachers, parents/guardians, and students

Answer : B.

248. When meeting with the school counselor, a student reveals that she often feels faint and has been losing a significant amount of hair. During the session, the counselor observes that the student makes several negative comments about herself and her appearance and that she is wearing clothes that are noticeably too large. The student's disclosures and behaviors are most likely indicative of which of the following problems?

1. drug or alcohol abuse
2. a mood disorder
3. physical abuse
4. an eating disorder

Answer : D

249. A teacher at an elementary school dies suddenly during the school year and the school counselor is notified. The counselor's *initial* action in this situation should be to:

1. offer to help plan a memorial service for the teacher.
2. assemble the school's crisis response team.
3. schedule individual and group counseling for students.

4. announce the school's cancellation for the rest of the week.

**Answer : B**

**250. A school counselor meets with a student who has shown signs of depression, including social withdrawal and loss of interest in previously enjoyed activities. At one point during the meeting, the student discloses having recurring thoughts about suicide. Which of the following would be the counselor's best response in this situation?**

1. pointing out to the student that suicide is an irreversible act
2. arranging to conduct a series of individual counseling sessions, beginning the following day
3. informing the student that the counselor must contact the student's family immediately
4. asking the student questions to evaluate the degree of risk

**Answer : D**

**251. A school counselor is planning a career development lesson focused on helping preteens expand their self-understanding. Which of the following types of assessments would likely be most effective to use in conjunction with this lesson?**

1. interest inventories
2. achievement tests
3. behavioral observations
4. intelligence tests

**Answer : A**

**252. A student with a physical disability is meeting with the school counselor to discuss postsecondary planning. The student is pessimistic about having a rewarding career and says that employers don't hire people with disabilities for anything but "boring jobs." Which of the following would be the counselor's best response?**

1. providing the student with examples of famous people with disabilities who have achieved success in various careers
2. reminding the student that individuals with disabilities have employment rights that are guaranteed by federal and state law
3. seeking out successfully employed individuals with similar disabilities who are

willing to serve as mentors to the student

4. pointing out that many individuals who start out in entry-level jobs achieve career success through persistence and hard work

Answer : C

253. Data on course enrollment at a high school indicate that students from a particular demographic group have been significantly underrepresented in college preparatory courses over the past four years. The school counselor's best initial response would be to:

1. develop in-service training for teachers on how to guide targeted students to enroll in advanced-level courses.
2. schedule a parent night focused on how students' course selections can affect their prospects for postsecondary success.
3. develop informational handouts for entering ninth graders that stress the idea that every student is capable of succeeding in college.
4. schedule a meeting with the school principal to assess the scope of the problem and begin developing an action plan.

Answer : D

254. A school counselor is reviewing a database of dropout rates for the school. The counselor sees that the school's ninth-grade dropout rate last year fell by 8 percent from the previous year. To obtain more precise information on school effectiveness, the counselor should take which of the following steps *next*?

1. inspect different graphic representations of the data
2. disaggregate the data by various student subgroups
3. review similar data for other middle schools in the region
4. extend the current trend to project next year's dropout rate

Answer : B

255. During a meeting with a school counselor, a student confides that she is pregnant and asks for information on obtaining an abortion. The counselor has a strong moral objection to abortion and is hesitant to provide the requested

**information. Under these circumstances, the counselor has an ethical responsibility to:**

1. **refer the student to another counselor at the school.**
2. **explain that many people believe abortion to be wrong.**
3. **suggest that the student consider alternative options.**
4. **probe the student's level of commitment to her decision.**

**Answer : A**

**256. Guidance refers to ___.**
**(A) An advice provided by superior to resolve problem**
**(B) A professional advice provided by Counselor in overcoming from personal or Psychological problems**
**(C) Both A & B**
**(D) None of the above.**
**Answer : A**

**257. Counseling refers to ___ .**
**(A) A Professional advice by Counselor**
**(B) An Advice by Elder**
**(C) Both A & B**
**(D) All of the above..**
**Answer : A**

**258. Which of the following is not the type of counseling?**
**(A) Marriage and Family Counseling**
**(B) Mental Health Counseling**
**(C) Substance Abuse Counseling**
**(D) Above All are types of Counselling**
**(E) None of the Above..**
**Answer : D**

**259. What does a school Counselor do?**
**(A) helping students in their academic goals**
**(B) helping students in social and personal development**
**(C) helping students in their career development**
**(D) All of the Above**
**(E) None of the above.**
**Answer : D**

**260. Guidance is a process of _____.**
**(A) to give advice to the child**
**(B) teaching English to the Child**
**(C) Both A & B**
**(D) None of the Above.**
**Answer : A**

**261. In Probing or Questioning from the Counselor enables what?**
**(A) to help students to move forward in helping process**
**(B) investigate other parts of his or her story**

**(C) Counselor can be with students physically or psychologically**
**(D) None of the Above..**
**Answer : A**

**262. The main aim of educational guidance is_____.**
**(A) Pupil Development**
**(B) To Solve the Problems**
**(C) Improvement of Curriculum**
**(D) None of the Above.**
**Answer : A**

**263. A school Counselor works in_____**
**(A) Primary , Middle and High Schools**
**(B) In Colleges**
**(C) In Universities**
**(D) None of the Above.**
**Answer : A**

**264. Main objective of educational guidance is to bring what change in the pupil____.**
**(A) Psychological Development of the child**
**(B) responsibility of self direction**
**(C) Both A & B**
**(D) None of te Above.**
**Answer : B**

**265. Name the person who is credited with Guidance Movement ?**
**(A) Einstein**
**(B) George Washington**
**(C) Frank Parsons**
**(D) All of the Above**
**Answer : C**

**266. What are the characteristics of Continuous and Comprehensive Evaluation?**
**(a) It increases the workload on students by taking multiple tests.**
**(b) It replaces marks with grades.**
**(c) It evaluates every aspect of the student.**
**(d) It helps in reducing examination phobia.**
**Select the correct answer from the codes given below:**
**(1) (a), (b), (c) and (d)**
**(2) (b) and (d)**
**(3) (a), (b) and (c)**
**(4) (b), (c) and (d)**
**Answer: 4**

**267. Which of the following attributes denote great strengths of a teacher?**
**(a) Full-time active involvement in the institutional management**
**(b) Setting examples**

**(c) Willingness to put assumptions to the test**
**(d) Acknowledging mistakes**
**Select the correct answer from the codes given below:**
**(1) (a), (b) and (d)**
**(2) (b), (c) and (d)**
**(3) (a), (c) and (d)**
**(4) (a), (b), (c) and (d)**
**Answer: 2**

**268. Which one of the following statements is correct in the context of multiple - choice type questions?**
**(1) They are more objective than true-false type questions.**
**(2) They are less objective than essay type questions.**
**(3) They are more subjective than short-answer type questions.**
**(4) They are more subjective than true-false type questions.**
**Answer: 1**

**269. What are required for good teaching?**
**(a) Diagnosis**
**(b) Remedy**
**(c) Direction**
**(d) Feedback**
**Select the correct answer from the codes given below:**
**(1) (a), (b), (c) and (d)**
**(2) (a) and (b)**
**(3) (b), (c) and (d)**
**(4) (c) and (d)**
**Answer: 1**

**270. The main objectives of student evaluation of teachers are:**
**(a) To gather information about student weaknesses.**
**(b) To make teachers take teaching seriously.**
**(c) To help teachers adopt innovative methods of teaching.**
**(d) To identify the areas of further improvement in teacher traits.**
**Identify the correct answer from the codes given below:**
**(1) (a) and (b) only**
**(2) (b), (c) and (d) only**
**(3) (a), (b) and (c) only**
**(4) (a) only**
**Answer: 2**

**271. Identify the important element a teacher has to take cognizance of while addressing students in a classroom.**
**(1) Avoidance of proximity**
**(2) Voice modulation**
**(3) Repetitive pause**
**(4) Fixed posture**
**Answer: 2**

**272. As a teacher, select the best option to ensure your effective presence in the classroom.**
**(1) Use of peer command**
**(2) Making aggressive statements**
**(3) Adoption of well-established posture**
**(4) Being authoritarian**
**Answer: 3**

**273. Which set of learner characteristics may be considered helpful in designing effective teaching-learning systems? Select the correct alternative from the codes given below:**
**(i) Prior experience of learners in respect of the subject.**
**(ii) Interpersonal relationships of learner's family friends.**
**(iii) Ability of the learners in respect of the subject.**
**(iv) Student's language background.**
**(v) Interest of students in following the prescribed dress code.**
**(vi) Motivational-orientation of the students.**
**Codes:**
**(1) (i), (ii), (iii) and (iv)**
**(2) (i), (iii), (iv) and (vi)**
**(3) (ii), (iii), (iv) and (v)**
**(4) (iii), (iv), (v) and (vi)**
**Answer: 2**

**274. The use of teaching aids is justified on the grounds of:**
**(1) attracting students' attention in the class room.**
**(2) minimising indiscipline problems in the classroom.**
**(3) optimising learning outcomes of students.**
**(4) effective engagement of students in learning tasks.**
**Answer: 3**

**275. Select the alternative which consists of positive factors contributing to effectiveness of teaching:**
**List of factors:**
**(a) Teacher's knowledge of the subject.**
**(b) Teacher's socio-economic background.**
**(c) Communication skill of the teacher.**
**(d) Teacher's ability to please the students.**
**(e) Teacher's personal contact with students.**
**(f) Teacher's competence in managing and monitoring the classroom transactions.**
**Codes:**
**(1) (b), (c) and (d)**

**(2) (c), (d) and (f)**
**(3) (b), (d) and (e)**
**(4) (a), (c) and (f)**
**Answer: 4**

**276. Which of the following set of statements represents acceptable propositions in respect of teaching-learning relationships? Choose the correct code to indicate your answer.**
**(i) When students fail in a test, it is the teacher who fails.**
**(ii) Every teaching must aim at ensuring learning.**
**(iii) There can be teaching without learning taking place.**
**(iv) There can be no learning without teaching.**
**(v) A teacher teaches but learns also.**
**(vi) Real learning implies rote learning.**
**Codes:**
**(1) (ii), (iii), (iv) and (v)**
**(2) (i), (ii), (iii) and (v)**
**(3) (iii), (iv), (v) and (vi)**
**(4) (i), (ii), (v) and (vi)**
**Answer: 2**

**277. Effectiveness of teaching has to be judged in terms of**
**(1) Course coverage**
**(2) Students' interest**
**(3) Learning outcomes of students**
**(4) Use of teaching aids in the classroom**
**Answer: 3**

**278. In which teaching method learner's participation is made optimal and proactive?**
**(1) Discussion method**
**(2) Buzz session method**
**(3) Brainstorming session method**
**(4) Project method**
**Answer: 4**

**279. One of the most powerful factors affecting teaching effectiveness is related to the**
**(1) Social system of the country**
**(2) Economic status of the society**
**(3) Prevailing political system**
**(4) Educational system**
**Answer: 4**

**280. Assertion (A): Formative evaluation tends to accelerate the pace of learning.**
**Reason (R): As against summative evaluation, formative evaluation is highly reliable.**
**Choose the correct answer from the following code:**
**(1) Both (A) and (R) are true and (R) is the correct explanation of (A).**

**(2) Both (A) and (R) are true, but (R) is not the correct explanation of (A).**
**(3) (A) is true, but (R) is false.**
**(4) (A) is false, but (R) is true.**
**Answer: 3**

**281. Which of the following set of statements best represents the nature and objective of teaching and learning?**
**(a) Teaching is like selling and learning is like buying.**
**(b) Teaching is a social act while learning is a personal act.**
**(c) Teaching implies learning whereas learning does not imply teaching.**
**(d) Teaching is a kind of delivery of knowledge while learning is like receiving it.**
**(e) Teaching is an interaction and is triadic in nature whereas learning is an active engagement in a subject domain.**
**Code:**
**(1) (a), (d) and (e)**
**(2) (b), (c) and (e)**
**(3) (a), (b) and (c)**
**(4) (a), (b) and (d)**
**Answer: 2**

**282. From the list given below identify the learner characteristics which would facilitate teaching learning system to become effective. Choose the correct code to indicate your answer.**
**(a) Prior experience of learner**
**(b) Learner's family lineage**
**(c) Aptitude of the learner**
**(d) Learner's stage of development**
**(e) Learner's food habits and hobbies**
**(f) Learner's religious affiliation**
**Code:**
**(1) (a), (c) and (d)**
**(2) (d), (e) and (f)**
**(3) (a), (d) and (e)**
**(4) (b), (c) and (f)**
**Answer: 1**

**283. Assertion (A): All teaching implies learning.**
**Reason (R): Learning to be useful must be derived from teaching.**
**Choose the correct answer from the following:**
**(1) Both (A) and (R) are true and (R) is the correct explanation of (A).**
**(2) Both (A) and (R) are true but (R) is not the correct explanation of (A).**
**(3) (A) is true, but (R) is false.**
**(4) (A) is false, but (R) is true.**
**Answer: 3**

**284. On the basis of summative tests, a teacher is interpreting his/her students, performance in terms of their wellness life style evident in behaviour. This will be called:**
**(1) Formative testing**
**(2) Continuous and comprehensive evaluation**
**(3) Norm - referenced testing**
**(4) Criterion - referenced testing**
**Answer: 4**

**285. Which one of the following is a key behaviour in effective teaching?**
**(1) Using student ideas and contribution**
**(2) Structuring**
**(3) Instructional variety**
**(4) Questioning**
**Answer: 3**

**286. Which of the following set of statements best describes the nature and objectives of teaching? Indicate your answer by selecting from the code.**
**(a) Teaching and learning are integrally related.**
**(b) There is no difference between teaching and training.**
**(c) Concern of all teaching is to ensure some kind of transformation in students.**
**(d) All good teaching is formal in nature.**
**(e) A teacher is a senior person.**
**(f) Teaching is a social act whereas learning is a personal act.**
**Code:**
**(1) (a), (b) and (d)**
**(2) (b), (c) and (e)**
**(3) (a), (c) and (f)**
**(4) (d), (e) and (f)**
**Answer: 3**

**287. Which of the following learner characteristics is highly related to effectiveness of teaching?**
**(1) Prior experience of the learner**
**(2) Educational status of the parents of the learner**
**(3) Peer groups of the learner**
**(4) Family size from which the learner comes.**
**Answer: 1**

**288. In the two sets given below Set - I indicates methods of teaching while Set - II provides the basic requirements for success/effectiveness. Match the two sets and indicate your answer by choosing from the code:**

| Set - I (Method of teaching) | Set - II (Basic requirements for success/effectiveness) |
|---|---|
| (a) Lecturing<br>(b) Discussion in groups<br>(c) Brainstorming<br>(d) Programmed Instructional | (i) Small step presentation with feedback provided<br>(ii) Production of large number of ideas<br>(iii) Content delivery in a lucid language<br>(iv) Use of teaching-aids procedure<br>(v) Theme based interaction among participants |

Code:

| | (a) | (b) | (c) | (d) |
|---|---|---|---|---|
| (1) | (i) | (ii) | (iii) | (iv) |
| (2) | (ii) | (iii) | (iv) | (v) |
| (3) | (iii) | (v) | (ii) | (i) |
| (4) | (iv) | (ii) | (i) | (iii) |

Answer: 3

289. From the list of evaluation procedures given below identify those which will be called 'formative evaluation'. Indicate your answer by choosing from the code:

(a) A teacher awards grades to students after having transacted the course work.

(b) During interaction with students in the classroom, the teacher provides corrective feedback.

(c) The teacher gives marks to students on a unit test.

(d) The teacher clarifies the doubts of students in the class itself.

(e) The overall performance of a students is reported to parents at every three months interval.

(f) The learner's motivation is raised by the teacher through a question-answer session.

Code:

(1) (a), (b) and (c)

(2) (b), (c) and (d)

(3) (a), (c) and (e)

(4) (b), (d) and (f)

Answer: 4

290. Assertion (A): All teaching should aim at ensuring learning.

Reason (R): All learning results from teaching.

Choose the correct answer from the following code:

(1) Both (A) and (R) are true, and (R) is the correct explanation of (A).

(2) Both (A) and (R) are true, but (R) is not the correct explanation of (A).

(3) (A) is true, but (R) is false.

(4) (A) is false, but (R) is true.

Answer: 3

**291. Individual therapy meets the standard of best practices when it includes all of the following EXCEPT**

- a. Theory choice
- b. Adherence and familiarity with only one theory
- c. Determination of the cultural relevance of the selected theory
- d. Appraisal of the empirical evidence for and against the selected theory for the case at hand.

**Answer: B**

**292. The interview accomplishes all of the following major social work tasks, EXCEPT:**

- a. The establishment of rapport
- b. The gathering of information necessary for assessment
- c. The enactment of a therapeutic process
- d. The acquisition of declarative knowledge

**Answer: D**

**293. A generic planned change process of social work practice consists of:**

- a. Rapport (establishment of a working relationship)
- b. Assessment
- c. Contracting
- d. Goal Setting
- e. All of the above

**Answer: E**

**294. Historically direct social work practice has been conceptualized in all of the following ways EXCEPT:**

- a. Casework
- b. Case Management
- c. Individual psychotherapy
- d. Generalist practice
- e. Policy practice

**Answer: E**

**295. Therapy has been informed by all of the following theories EXCEPT**

- a. Pharmacological
- b. Psychodynamic
- c. Cognitive-Behavioral
- d. Narrative
- e. All of the above

**Answer: E**

296. Indirect practice has been conceptualized overtime in all of the following ways EXCEPT:

a. As private practice

b. As administrative or management practice

c. As planning and organizational practice

d. As community organizing and social action practice

e. As policy practice

Answer: A

297. According to Biesteck, all of the following are core values in direct social work practice, EXCEPT:

a. Acceptance

b. Non-judgmental attitude

c. Confidentiality

d. Client self-determination

e. All of the above

Answer: E

298. Declarative knowledge consist of all of the following, EXCEPT:

a. Intuitive and creative knowing in the therapeutic moment

b. A cognitive map of learned (taught) concepts

c. Causal knowledge of individual resilience

d. Causal knowledge of individual vulnerability

Answer: A

299. All of the following are aspects of tacit knowing EXCEPT:

a. Use of highly disciplined and automatic procedural knowing

b. Self-regulated ability to reflect and adjust performance in the therapeutic moment

c. Ability to reflect on action

d. Ability to reflect in action

Answer: C

300. Managing transference and counter-transference is critical in which one of the following theory-based models of therapy?

a. Behavior modification

b. Cognitive-behavioral therapy

c. Psychodynamic models of therapy

d. Solution-focused models of therapy

Answer: C

**301. Emphasis on the construction of reality is emphasized in which one of the following theory-based models of therapy?**

- a. Behavior-Modification
- b. Strengths-based model
- c. Psychodynamic models
- d. Power alignments

**Answer: C**

**302. All of the following are indicators that the helping relationship or therapeutic process is not going well EXCEPT:**

- a. The client frequently misses, cancels, or is tardy to appointments
- b. The client asks questions and seeks information about which the worker is not knowledgeable
- c. The client rambles on at length; focuses on irrelevant matters or details
- d. The client minimizes the problem or claims miraculous improvement Matching

**Answer: B**

**303. Some of the greatest advances in human civilization in the 20th century have been:**
**A. the discovery of antibiotics**
**B. the discovery of DNA**
**C. the marked lengthening of the average life span**
**D. the improvement of public health**
**E. all of the above**
**Answer: E**

**304. At present, the longest living human, has lived the following number of years:**
**A. 122**
**B. 114**
**C. 130**
**D. 150**
**E. none of the above**
**Answer: A**

**305. Currently, the major cause of death in old age, in the US is:**
**A. cardiovascular diseases: heart disease and stroke**
**B. cancer**
**C. pneumonia**
**D. diabetes**
**E. dementia**
**Answer: A**

**306. By "rectangularization" of the survivorship curve, we mean:**

**A. compression of morbidity**
**B. expansion of morbidity**
**C. worse performance of the ADLs**
**D. better performance of the IADLs**
**E. none of the above**
**Answer: A**

**307. There are some ethnic/gender differences in the causes of death in the US population EXCEPT:**
**A. Alzheimer's dementia is more frequent in women than men irrespective of ethnicity**
**B. in men, diabetes is more frequent in American Indians and Alaska natives than whites**
**C. in men, hypertension is more frequent in African Americans than in all other ethnic groups**
**D. cancer is more frequent in whites than in all other groups**
**E. the frequency of heart disease is the same across all ethnic groups**
**Answer: D**

**308. Which of the following is DIRECTLY CORRELATED with longevity:**
**A. Basal Metabolic Rate**
**B. Stress**
**C. Length of Growth Period**
**D. Reproductive Fecundity**
**E. All of the Above**
**Answer: C**

**309. Which of the following can induce Cellular Senescence:**
**A. Replicative Senescence**
**B. DNA Damage**
**C. Oncogene Expression**
**D. Super-Mitogenic Signals**
**E. All of the Above**
**Answer: E**

**310. Which of the following is NOT a source of free radicals:**
**A. p450 enzyme**
**B. Macrophages and Neutrophils**
**C. Alloxan**
**D. Lipid Peroxidation**
**E. None of the Above**
**Answer: D**

**311. Which of the following is generally true for sex differences after 65 years of age:**
**A. men live longer but have more physical trauma injuries than women**
**B. women live longer but have greater dependency (more disabilities) than men**
**C. women live longer and have fewer disabilities than men**
**D. there is no difference in life expectancy but women have fewer**

**disabilities**
**E. none of the above**
**Answer: B**

**312. How have the major causes of death in the U.S. changed over the past century:**
**A. shift from accidents and natural disasters (e.g. floods, earthquakes, etc.) toward microbial diseases**
**B. the major causes of death have remained unchanged**
**C. shift from microbial diseases and cancer toward natural disasters and food-borne illnesses**
**D. shift from microbial diseases toward cardiovascular disease and cancer**
**E. shift from cancer and accidents toward microbial diseases**
**Answer: D**

**313. What happens when telomere length is critically shortened?**
**A. cells undergo irreversible arrest of cell proliferation**
**B. they show altered function**
**C. alteration in function is universal**
**D alteration in function is cell-type specific**
**E. all of the above**
**Answer: A**

**314. All the following statements regarding telomerase are true, EXCEPT:**
**A. somatic cells have telomerase activity throughout their lives because of their high activity levels**
**B. germline cells have telomerase activity because of the importance of retaining all their genetic information**
**C. telomerase is expressed in 80% of tumor cells**
**D. telomerase is expressed in some stem cells but it is highly regulated**
**E. telomerase overcomes telomere shortening**
**Answer: A**

**315. How are anti-oxidants believed to be helpful to our bodies?**
**A. they antagonistically bind to oxygen molecules, thus preventing aerobic pathways**
**B. they enhance free-radical formation, thus increasing the efficiency of cellular processes**
**C. they "quench" the reactivity of reactive oxygen species, thus preventing their detrimental interactions with other cellular activities**
**D. they complex with vitamins in our bodies to produce reactive oxygen**

**species, which are then used to enhance aerobic pathways**
**E. none of the above**
**Answer: C**

**316. *Ageism***
**A. has the same meaning as senescence**
**B. is a term indicating discrimination or prejudice against the elderly**
**C. has the same meaning as aging**
**D. none of the above**
**E. all of the above**
**Answer: B**

**317. In elderly humans, "successful aging" is characterized by:**
**A. presence of illnesses but no decline in function**
**B. absence of illnesses and absence of decline in function**
**C. decline in function but no illnesses**
**D. changes in chronological age but not physiological age**
**E. none of the above**
**Answer: B**

**318. Functional competence and, inversely, degree of disability in the elderly may be measured by:**
**A. Counting the number of activities of day living that the old person can perform**
**B. Counting the number of instrumental activities of day living that the old person can perform**
**C Evaluating the degree of performance in both activities and the absence of disabilities**
**D. Estimating the degree of functional independence that allows the old person not to be institutionalized in a nursing home**
**E. all of the above**
**Answer: E**

**319. The number of centenarians, in the last century as compared to the previous centuries has:**
**A. remained unchanged worldwide**
**B. increased in developed countries**
**C. increased in developing countries**
**D. decreased in developing countries**
**E. decreased in developed countries**
**Answer: B**

**320. Mice with cells that do not senesce die young of cancer because:**
**A. Cellular senescence represents an important tumor suppression mechanism**
**B. tumor cells may be considered immortal**
**C. tumor cells continue to divide and cause death of the host organism**

**D. the two most important tumor suppressor pathways (p53 & pRB) are missing**
**E. all of the above**
**Answer: E**

**321. Disease in the elderly has the following characteristics, EXCEPT:**
**A. symptoms are vague and atypical**
**B. diseases are chronic as opposed to acute**
**C. diseases are acute as opposed to chronic**
**D diseases often affect many systems simultaneously**
**E. diseases may induce responses to treatment different from those of young & adult persons**
**Answer: C**

**322. Aging and disuse have many similarities; in both cases the following responses occur EXCEPT:**
**A. maximum oxygen consumption decreases**
**B. cardiac output decreases**
**C. blood pressure increases**
**D. in all cases, only young people are able to benefit from exercise**
**E . in all cases both young and old people are able to benefit from exercise.**
**Answer: D**

**323. Which of the following theories is most quantitatively measurable ?**
**1 Pavlov's**
**2 Skinner's**
**3 Hull's**
**4 None of these**
**Answer: Skinner's**

**324. Theory of generalization is similar to the theory of**
**1 Transposition**
**2 Identical elements**
**3 Both of these**
**4 None of these**
**Answer: Identical elements**